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# *The* WISCONSIN MEDICAL JOURNAL

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# THE WISCONSIN MEDICAL JOURNAL


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# . . . . The President's Page . . . .

A FEW weeks ago Dr. N. A. Hill, councilor from the third district, Dr. John Curtis, a member of our Committee on Public Policy, and I had a very interesting meeting with members of the State Board of Medical Examiners. While it might be a little strong to say that they are entirely agreed about all the recent revisions of the Medical Practice Act, it is perfectly obvious that they are determined to administer the law to the best of their ability.

During the course of our discussion, a curious fact came to light which I believe is worth mentioning. It seems that several of the Board members have received considerable personal criticism from some of their colleagues for granting the unlimited license to some osteopaths, the assumption on the part of these critics being that this whole matter of full license for osteopaths is a prerogative of the Board members. It should not be, but obviously is, necessary to remind our colleagues that the law permitting osteopaths to take examinations for full license was approved by the State Medical Society. Thus it is a matter of statute that osteopaths may apply for examination, and the function of the Board is to verify the applicants' qualifications and to conduct the examinations in accordance with the law. And it might be of interest to know that the Board has evolved a system that precludes the grader knowing whether it is the paper of an M. D. or a D. O. that he is grading.

It is probably safe to say that this law does not have the unqualified approval of all physicians in the state. But nevertheless it is the law, and it will undoubtedly be the law for many years to come. There are many indications that the education given in osteopathic schools is rapidly approaching that given in medical schools; and as soon as the osteopathic schools will submit to the same evaluation now required of medical schools, the way will be cleared for a substantial increase in the number of physicians qualified to treat the sick.

H. Kent Tenney M.D.

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# Your Partner—The State Medical Society

EVERY physician in Wisconsin profits from the activities of the State Medical Society of Wisconsin. The degree to which each physician benefits depends much upon his membership and his knowledge of how his Society operates. Every person in the state owes much to its existence. Yet, the public, like many physicians, is unaware of the scope and importance of the Society's work. This article is presented so that every physician may know how the Society benefits him and the public.

The State Medical Society of Wisconsin was created by an act of the Territorial Legislature in 1841, seven years before Wisconsin became a state. The Society is dedicated "to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life." The Society was organized in Madison by 13 physicians who attended its first meeting.

A nonprofit, public service organization, the Medical Society is democracy in its most effective form. Any reputable Doctor of Medicine may join his local county medical society. Wisconsin has 52 county medical societies whose members number nearly 3,200. Each of these county societies elects delegates to the House of Delegates of the State Medical Society—one delegate for each 50 full dues-paying members. The State Society House of Delegates, in turn, elects three delegates to the American Medical Association to represent Wisconsin doctors at the national level.

The delegates meet annually to determine the policies and program of the State Medical Society. Dues are established at this session. Between meetings, the Council has the full power and authority of the House of Delegates. It consists of the president, president-elect, past-president, speaker of the House of Delegates, treasurer, secretary, and 17 councilors. Each of the councilors serves one of the 13 medical districts into which the state has been divided.

The day-to-day affairs of the Society are supervised and coordinated by the Secretary. A full-time staff of about 65 persons is required to carry out the activities authorized by the House of Delegates and Council. All of the Society's activities are housed in the Society's headquarters at 704 East Gorham Street, Madison. Land, building, and equipment are completely free of debt. Because of expanding needs, the Society has purchased land on the south shore of Lake Monona in Madison on which it plans to construct a larger headquarters and ultimately dispose of its present location. Society members are invited to visit the State Society office at any time.

Most State Medical Society activities are financed from membership dues, although many are largely self-supporting. For example, it costs about $25,000 a year to publish *The Wisconsin Medical Journal,* and all but about $4,000 is recovered from advertising. The Blue Shield Plan of Surgical-Medical Insurance is completely self-supporting in its administrative aspects. The total cost of the Annual Meeting is about $18,000 annually, and all but about $1,000 is recovered from the sale of exhibit space and luncheon tickets.

**The State Medical Society headquarters at 704 East Gorham Street in Madison houses nearly 65 employees, all Society activities and agencies, and a combined meeting-dining room.**

The total annual budget of the Society is about $200,000. The Audit and Budget Committee makes a periodic and detailed study of the income and expenditures of the Society every year with a view to assuring the profession that it's "getting its money's worth" for its dues and that Society funds are being spent legally and appropriately. A complete and simplified explanation of the Society's annual budget is printed in *The Wisconsin Medical Journal* in either the May or June issue.

The Council meets from four to six times a year and its members are in constant contact with the Society office. Each of the 38 committees of the Society meets an average of four times a year to deal with the many and complex problems placed before it. Since councilors, officers, and committeemen serve without pay, acceptance of such positions means substantial personal sacrifice of time and money.

## BENEFITS FOR THE PHYSICIAN

### A Better Education

Medical education in Wisconsin is better because of the State Medical Society. The University of Wisconsin Medical School owes its existence, in part, to the Society's early efforts to bring a professional school to the campus. The Committee on Medical Education and Hospitals works with the deans at both Marquette and Wisconsin to improve curricula, to make the best possible use of clinical material, and to develop the preceptor programs. The Society helps the American Medical Education Foundation of the AMA to raise money from the medical profession to support medical schools. Schools may use the money in whatever way they wish—for faculty, buildings, research, and the like. In addition, the State Medical Society has established a Student Loan Fund to help needy and deserving medical students get through school. The Fund hopes to raise $250,000. It already has about $15,000 and made four loans in 1953. Through the legislature, the Society works to increase facilities for the output of doctors. In the 1953 session the Society helped secure passage of a measure providing $1,400,000 for new medical buildings at the University of Wisconsin.

### A Place to Practice

Whenever a doctor is looking for a place to practice—whether he is just out of school or seeking a change—his best bet is the Society's physician location service. This service keeps complete, up-to-date files on communities wanting physicians and physicians seeking locations. For the asking, a physician can get a full list of opportunities for full-time individual practice, locum tenens positions, and partnership or association. The Society cooperates with the American Medical Association's placement service to give physicians first-hand information on a national basis. Arrangements have been made with the armed forces to provide the military physician with full details about Wisconsin locations for practice prior to his release from service.

### Postgraduate Education

The Council on Scientific Work is the nerve center of the Society's scientific affairs. It plans the scientific sessions of the Annual Meeting and a variety of local or regional meetings. Through it the Society provides an annual three-day scientific session including general and specialty lectures, demonstrations, "wet clinics," motion pictures, and scientific and technical exhibits.

In addition, nearly 20 individual teaching programs are organized in monthly circuits through the state to provide physicians with unusual opportunities for scientific training without undue absence from their practices. In single afternoon programs, repeated at various locations, doctors may hear outstanding medical teachers brought to Wisconsin from the nation's medical centers.

Special scientific sessions on cancer, psychiatric problems, and the like are arranged from time to time in different areas of the state. Government and voluntary agencies cooperate in these programs. These meetings are brought to the membership at a cost of less than 50 cents per member. This is possible because of the cooperation of the State Board of Health, the Wisconsin Heart Association, the Wisconsin Division of the American Cancer Society, Wisconsin's two medical schools, the Wisconsin Academy of General Practice, and the Wisconsin Anti-Tuberculosis Association.

**Postgraduate education for physicians includes the Annual Meeting and at least 20 separate teaching clinics throughout each year.**

### Journal Keeps Doctors Informed

Every month *The Wisconsin Medical Journal* goes to nearly 3,500 physicians. It goes to every member of the State Medical Society. Others subscribe individually. The *Journal* is a constant source of postgraduate education for both the general practitioner and the specialist. It stimulates Wisconsin physicians to investigate clinical problems and publish their observations. Of the more than 100 pages of each monthly issue, about 30 are assigned to scientific reading matter, 30 to organizational material, and the remainder to advertising. It contains editorials, a unique green sheet section on medical economics and public relations, and special sections from agencies and interests concerned with medicine and public health. The *Journal*, in its 93rd year, is under the direction of the Council on Scientific Work, a medical editor, an editorial board, and an advertising committee.

### Medicine's "Blue Book"

Every five years the State Medical Society publishes its "Medical Blue Book," a guide for practitioners in their personal and professional affairs with patients, courts, social and governmental agencies, and the community. This special edition is kept up to date annually with the publication of the

January issue of *The Wisconsin Medical Journal* as a "Blue Book Supplement." There isn't a physician in the state who can't profit from the contents of these two books—making a will, testifying in court, malpractice, services of state and voluntary health agencies, adoption procedures, medical partnerships, medical ethics, medical licensing laws, licensing of limited practitioners, agreements of lease, fee splitting, selling a practice, collection of accounts, narcotics laws, hospital records, and the like.

### Questions About Medical Products and Devices

Whenever a physician has questions about drugs, diagnostic and therapeutic devices, and other products used in the practice of medicine, he should feel free to write to the State Medical Society. Hundreds of such requests are answered each year. Most of these products and devices are evaluated or tested by the American Medical Association. The doctor may contact the AMA directly or ask the State Society to help.

### Cancer Detection and Control

Early detection is one of the secrets of cancer control. For the public this means knowing how to recognize the symptoms, when to see the doctor, and what to expect of him. For the doctor this means knowing and utilizing the best methods of detection and treatment. Both interests are served by the State Medical Society. Its Committee on Cancer serves as the medical and scientific committee of the Wisconsin Division of the American Cancer Society. It develops professional education projects in cancer throughout the state, influences the training of technicians in cancer detection and control, and produces public education leaflets. One example is "What You Can Expect of a Cancer Examination," a small but effective pamphlet of which over 500,000 copies have already been distributed through doctors' offices and other avenues. The Society does everything possible to impress the public with the fact that the private practitioner is trained to serve as a "cancer detection center."

### Blood Bank Problems

Advice to doctors in handling blood bank problems is provided through the Committee on Blood Banks. It helped develop the gamma globulin polio prevention program in Wisconsin. It evaluates blood procurement policies, helps develop adequate medical supervision of civilian and military procurement, and serves as a review board for any hospital or doctor having a complaint about any blood bank program.

### The Doctor and the Hospital

Sometimes it isn't easy for the doctor to find a proper and suitable financial and contractual relationship between himself and a hospital, particularly in the fields of pathology, radiology, anesthesiology, or physiatry. That's where the State Medical Society can help. Through the Committee on Hospital Relations and the staff, specific complaints from physicians or hospitals can be adjudicated; sometimes situations can be resolved before they become problems. Furthermore, this committee has conducted surveys to determine what, when, where, and how radiology and pathology services can be made available either part time or full time in communities throughout the state.

### "Problems of State Medicine"

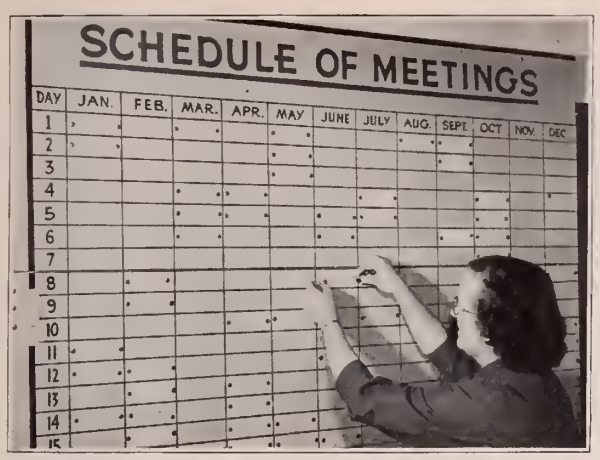
One of the purposes of the Medical Society as defined in 1841 is to deal effectively with "problems of state medicine." The founders of the Society could hardly have foreseen the extent and complexity of governmental and private agency activities in the field of public health and medicine. Today a significant portion of the State Medical Society's effort is directed to work with the state departments and voluntary agencies. The very nature and scope of public health problems today makes it imperative that the State Medical Society assume for the physician—and the public—many of the roles which in an earlier era were performed by the individual physician. In caring for his own patients, the physician can and must act as he always has. But sheer size and complexity often dwarf individual effort and demand coordinated action for effectiveness in broad public health matters. It is here that the State Medical Society performs a great service for the profession and public through the Commission on State Departments and its nine divisions:

### . . . On Crippled Children

Orthopedic clinics have been developed throughout the state in cooperation with the Bureau of Handicapped Children of the State Department of Public Instruction. These have improved the effectiveness of proper diagnostic services available to family physicians and their patients. Outpatient services have been developed for rheumatic fever victims. A basic outline for the development of a rheumatic fever program has been prepared for county medical societies. Study is given to special clinics for the cerebral palsied, the epileptic, and children with cleft palate.

### . . . On Geriatrics

Many state and voluntary agencies are concerned about the growing number of "old people" and their problems. The State Medical Society is trying to coordinate and guide these groups in their thinking on how to handle medical service, nutritional needs, and economic problems of the aged. It is preparing a guide for county medical societies concerned with developing homes and other facilities for the aged. It is working on how best to extend public welfare services to the aged at minimum cost. It seeks to coordinate public information about problems of "growing old."




**The activities of some 38 Councils and Committees fill the calendar with meeting dates the year around.**

### . . . On Maternal and Child Welfare

Never before has the Wisconsin physician had such opportunity to benefit from clinical scientific studies on a significant patient problem—maternal mortality and fetal and neonatal deaths. In cooperation with the State Board of Health, the State Medical Society is making a comprehensive analysis of each maternal death. Through the cooperation of selected hospitals with pathologic service and the active participation of the Wisconsin Society of Pathologists, a series of pilot studies is being conducted in the fields of fetal and neonatal mortality. The facts, along with helpful advice, are given to the doctor and the hospital, with complete anonymity for all. This is medical education at its finest. It is true public service. Through this phase of Society activity, physicians and hospitals also receive advice on the handling of prematures, hospital policies for obstetric patients, and collection of adequate data on death and birth certificates.

### . . . On Nervous and Mental Diseases

This is a problem loaded with public interest and opportunity for improvement. The State Medical Society advises the State Board of Health, the Department of Public Welfare, and the state legislature concerning personnel needs in the field of psychiatry, adequate medical supervision for mental health programs, provision of adequate facilities for state institutions, and more adequate medical examinations and general health care in county mental institutions. A special committee is reviewing existing statutes concerning medical aspects of court examinations and the apprehension and disposition of persons suffering from emotional disturbances. Other committees work on the care of emotionally disturbed children and means of remedying the shortage of trained psychiatric workers.

### . . . On Public Assistance

The physician and his method of caring for the indigent patient may be significantly affected by various trends and developments in public assistance policies of government at the local, state, and federal levels. The State Medical Society seeks to serve the best interests of both physician and patient by its contacts with government in the fields of poor relief, categorical aids, and the general administrative problems. Studies are made of county fee schedules, the effect of health insurance in this field, and the implications of treatment authorization procedures and limitations.

### . . . On Rehabilitation

Rehabilitation is rapidly gaining medical stature. By working closely with the Rehabilitation Division of the State Board of Vocational and Adult Education, the Medical Society assists in the development of adequate fee schedules for rehabilitation services. Educational programs in rehabilitation are held for the physician. The Society also helps the physician learn how, when, and where he can obtain rehabilitation services for his patients.

### . . . On School Health

Effective school health programs need careful medical guidance. The State Medical Society provides or stimulates this direction through conferences between physicians and school people and the development of recognized standards and guides for good school health programs. This is done in cooperation with the State Board of Health, the Department of Public Instruction, and the Wisconsin Cooperative School Health Council. The physician is aided, too, by the Society's influence on proper policies for conduct of competitive sports in elementary and junior high schools and the establishment of sound medical regulations for the Wisconsin Interscholastic Athletic Association sports and insurance program.

### . . . On Tuberculosis and Chest Diseases

Educational material for the physician to help him provide more intensive follow-up of suspected cases of tuberculosis is one aspect of the Society's effort in this field. The Society advises the State Board of Health and the Wisconsin Anti-Tuberculosis Association with regard to consultation services to county sanatoria, examination of teachers and other school employees, development of adequate legislation for free care of the tuberculous, and the like.

### . . . On Visual and Hearing Defects

A special guide has been developed by the Society to help physicians and others establish vision testing programs in Wisconsin. The Bureau of Handicapped Children of the State Department of Public Instruction, as well as other agencies, has the Society's advice and guidance in this field. The Society enlists the aid of physicians for follow-through on

cases in which hearing deficiencies are detected and studied at otologic clinics. Professional and executive education is furthered by a series of industrial hearing meetings which explore medical implications of noise exposure, its relation to compensation claims, and similar problems. To assist industry in the development of a hearing conservation program, a guide is being prepared to provide for wide participation by physicians trained to render this service. Physicians may request information on the use of state services for patients suffering serious vision loss.

### Admissions to Wisconsin General Hospital

The Society has played an important role in the development of policies governing the admission of private-pay and special patients to Wisconsin General Hospital at the University of Wisconsin. A Committee on Coordination of Medical Services continues to evaluate these policies with emphasis on their effect on the teaching of medical students and the ability of the hospital to serve the public.

### SMS Promotes Good Health Insurance

For nearly 20 years the State Medical Society has been influential in developing high quality programs to help people provide insurance protection for the costs of medical and surgical care. The Society's efforts are tremendously important to both physician and patient. Today a Commission on Prepaid Plans, made up of 17 member physicians from all parts of the state, directs all health insurance activities.

The Society owns and operates Wisconsin Physicians Service ("The Doctor's Plan"), the Blue Shield Plan of the State Medical Society. Its activities and employees are housed at the Medical Society headquarters. It provides insurance protection for doctors' services to nearly 300,000 persons in Wisconsin. During 1953 this plan provided payments of nearly $3,000,000 to Wisconsin physicians for their services to patients.

The Society also sponsors and approves The Wisconsin Plan, a program of medical-surgical protection sold through private insurance companies. The Medical Society sets up the minimum requirements under which the insurance companies may sell this plan. While this idea was unique with Wisconsin, eight or ten other states have since adopted it.

Both of these prepaid plans operate under identical fee schedules carefully worked out by the Society. In Blue Shield, all claims are administered by the Medical Society staff or committees of physicians. In The Wisconsin Plan, claim disputes are handled by the Medical Society. Undoubtedly, the prepaid plans have been a stabilizing influence on physicians' incomes. They are a boon to the public because they provide a device for economical financing of major health care costs while preserving the patient's free choice of physician.

**IBM equipment is used to keep membership records, pay Blue Shield claims, and conduct surveys on various subjects.**

### The Doctor's Partner in Veterans' Claims

The State Medical Society serves as the physician's partner in dealing with the Veterans Administration on claims for care provided to veterans with service-connected disabilities. Since 1947, the VA has contracted with the Society to make it possible for certain veterans to have the services of their personal, home-town physicians at government expense. The Society relieves the doctor of much detailed bookwork and correspondence with the VA. It goes to bat for the doctor and the veteran on justifiable claims. Through the Veterans Medical Service Agency of the Medical Society, nearly 100,000 claims have been handled for Wisconsin doctors since 1947. The total dollar value of these claims has been over $1,500,000. It is a successful demonstration of the profession's ability to maintain the doctor-patient relationship while helping Congress carry out its promise of adequate medical care for eligible veterans.

### Helping the Doctor in Industrial Cases

Through what is called the "Open Panel" program, the Society assures Wisconsin employees the privilege of choosing their own personal physicians for the care of industrial injuries. This has obvious advantages to doctors and employees. Annually the Society prepares and distributes to employers nearly 60,000 copies of "panels" of physicians in each county who wish to engage in the treatment of industrial cases. In addition, the Society adjudicates differences between insurance carriers, employers, and physicians participating in the program.

### Society Represents Doctors in Legislation

One of the important services which the State Medical Society performs for physicians is that of representing the medical profession before the state legislature and Congress. The Society sees its

duty to offer lawmakers facts about the health sciences, evaluation of health problems, and recommendations on translating new medical knowledge and developments into laws for improving and safeguarding the people's health. The Society's Committee on Public Policy and staff conduct long and detailed investigations into significant public health problems between sessions in order to present the legislature with the profession's best judgment for their solution. Every one of the thousand or more bills introduced in each session of the state legislature is carefully scrutinized. Committee members, staff, and legal counsel collect evidence, arrange appearances, and testify before legislative committees. Examples of the Society's efforts are apparent in the establishment of the State Board of Health, medical licensing laws, the University of Wisconsin Medical School, regulations permitting operation of voluntary prepaid health insurance plans, laws protecting the public from quackery and cultism, and the like.

The Public Policy Committee advises the Council and the House of Delegates on the position the Society should take on legislation. Its actions are subject to Council and House approval and must be taken within the framework of policy laid down by them. The entire membership of the Society is kept advised of the general content of all legislation and special efforts are made to inform county officers. The suggestions and advice of any member are welcomed at all times.

## Group Disability Program for Physicians

Of direct and personal benefit to a member of the State Medical Society is his eligibility to enroll in the Society's group accident, sickness, and hospitalization insurance program. Write for information. Benefits paid to insured physicians by the plan's underwriter, the Provident Life and Accident Insurance Company, total over $450,000 after three years of operation. More than 700 claims for disability benefits have been settled promptly and equitably. Disputes between a physician and the insurance company are investigated by the Society.

## Going Into Military Service?

Virtually every able-bodied physician in Wisconsin is subject to military service at some point in his professional career. The Committee on Military Medical Service and the staff—often in direct contact with officials of the armed forces—provide information and advice to any physicians faced with this interruption of civilian practice. Through the committee, recommendations are made to Selective Service and the reserve branches of the armed forces concerning the availability of physicians for active duty. Its primary purpose is to protect civilian medical service interests while at the same time providing a contribution to national defense.

## Records of All Physicians

A great deal of service is provided to Wisconsin physicians from the State Medical Society's files of detailed information about every physician in the state. This data, now kept manually on cards and in files, is being transferred to IBM cards. The records are invaluable in providing endorsements for reciprocity; adjudicating dues problems; handling subscriptions for the Journal of the AMA, its specialty journals, and *Today's Health;* providing information on the location of physicians, board-certified specialists, and qualifications of all physicians; identifying quacks who pose as M.D.'s; locating colleagues; determining the number and distribution of physicians; and aiding the equitable call-up of physicians in wartime. The membershp department of the Society also handles all mechanical details of obtaining physician participation in the prepaid insurance plans, veterans' care program, physicians' disability plan, and the open panel program.

**Records of every physician in Wisconsin are kept by the membership department. They are invaluable to doctors themselves and for many surveys.**

## Public Relations Aids

A wide variety of projects, programs, and tools developed by the State Medical Society and the American Medical Association are available through the Society office to help physicians in their public relations. Here are some:

*Medical-Press Conferences*—A series of conferences has been held around the state to help doctors and newsmen do a better job of working together to serve the public, each group in its own way. The Society is always ready to help individual physicians or county medical societies on problems with newspapers and radio or television stations.

*Round-the-Clock Medical Service*—The Society has made detailed studies of patterns of medical practice and how medical care is available throughout Wisconsin 24 hours every day. Still, some doctors need help in organizing effective emergency

service plans. The Society advises the profession and the public on the best methods of meeting this situation.

*Health Pamphlets*—A wide variety of pamphlets on health and medical economic problems are available upon request of the Society. Many pamphlets are free. Quantity orders of some pamphlets are available at cost. Pamphlets may be used to bolster the physician's verbal orders to his patients, to educate patients to better health practices, and to create understanding of medicine's efforts to build a healthier world. Write the State Medical Society for a list of public relations pamphlets.

*News Releases*—Periodic news releases are issued from the Society office to keep the public informed of Society activities, to alert the people to special health problems, and to tell the story of medicine's progress.

*Medicine on the Radio*—One of the Society's most valuable public relations projects for physicians and the public is "The March of Medicine," a weekly radio program produced on tape by the Society and presented as a public service by 43 radio stations. This 15-minute program provides the public with sound health advice on common problems and urges listeners to "see your family doctor" regularly. It is estimated that at least 300,000 persons hear each of the 52 yearly broadcasts. In addition, the Society provides all Wisconsin radio stations with spot announcements on good health practices.

*Health News for Industry*—Hundreds of industrial nurses in Wisconsin were without adequately prepared "hints for good health" until the Society began providing monthly bulletins. Now industrial house organs, plant bulletin boards, and monthly pay envelopes in many plants carry Medical Society advice for healthier living.

*First Aid Charts*—Public ignorance of proper first aid has often contributed to injury or even death. Sometimes it hinders the physician in proper treatment. The State Medical Society is attempting to counteract this problem by publishing colorful, cartoonlike first aid charts providing information on common accidents and conditions. Over 50,000 have already been distributed.

*Tape Recordings on Loan*—High schools desiring to use selected "March of Medicine" programs for teaching purposes can obtain these tape recordings on a loan basis. Tapes are currently loaned at a rate of 100 per month.

*Nurse Recruitment and Education*—With an eye to doing something to relieve the registered and trained practical nurse problem, the Society is making an intensive study of education and recruitment of nurses in Wisconsin. It is hoped this will produce direct benefits to doctors, hospitals, and patients.

*More Assistants for Physicians*—The recruitment of personnel for careers in fields allied to medicine —nursing, medical technology, laboratory work, medical secretarial work, pharmacy, public health work, and the like—is encouraged through the distribution of recruitment literature and assistance to high schools planning career days for students.

*Public Meetings*—Speakers, films, exhibits, and pamphlets are provided for meetings sponsored by physicians, woman's auxiliary groups, or others on topics related to personal health or economic and social aspects of medicine. Loan packets are available on a wide variety of health subjects for meetings, students, and the like.

### "Personal Service" to Physicians

While many of the Society's activities lend themselves to classification as projects and programs outlined previously, a tremendous amount of the Society's effort can be classified in no other way than as "personal service" to individual physicians. Day-to-day correspondence between members, the public, and the Society is responsible for much staff time and effort. Each of the inquiries presents a particular problem; and while some may be relatively routine, others require detailed study and research, conferences for a decision on means of expressing the Society's policy, and sometimes reference to appropriate committees or councils of the Society for final determination.

Medical-legal problems constitute a large proportion of such inquiries. Typical of these are requests for information on the legal aspects of medical testimony, sale and use of narcotics, access to hospital records, Workmen's Compensation Act and estimation of permanent disability, release of information about patients to the press, licensing, establishing and operating a practice, and an almost unlimited number of similar questions.

Building an office can be quite a problem for a physician. The Society has a collection of information about floor plans and "pointers" to keep in mind when constructing office facilities. The Society also

**Incoming and outgoing mail is counted in the hundreds of thousands of pieces every year.**

provides information on agreements of lease, the selling price of a medical practice, and arranging a partnership.

The Society also helps its member physicians by providing facts on business methods, insurance and financial problems, taxation, medical care costs, voluntary health insurance, government medical services, state and federal legislation, physician and hospital relations, medical education, hospitals and physician supply and distribution.

### Service to the Public

Many of the projects outlined previously have obvious direct benefit for the public. Conferences, radio and TV shows, newspaper releases, pamphlets, answering letters, exposing quackery, assuring well-trained and constantly up-to-date physicians, proposing and supporting sound medical and health legislation, and cooperating with public groups in many health education projects are typical of the public service efforts of the State Medical Society.

Of special significance is the Committee on Grievances, which provides a facility to which the public may bring its problems, its complaints, and its "gripes" concerning an individual physician, physicians as a profession, or the medical care situation in a particular area. The Committee may consider as many as 100 matters during the course of a year, but that is not indicative of the total picture. Many are handled by county societies. The total yearly contacts between physicians and patients must be counted in the millions. In the physician's daily contact with the sick, he is necessarily confronted with emotional stress and deep personal concern, the perfect culture in which to breed possible misunderstanding and dissatisfaction. The Committee's work involves detailed and deliberate case study and interview, patience and painstaking investigation, soundly-considered advice, and even discipline of physicians of all ages and types of practice. Its activities may have a tremendous influence on patterns of practice and the status of doctor-patient relationships in general.

Considerable effort is expended by the Society in planning for the care of casualties in the event of natural or wartime disasters. The Committee on Civil Defense has prepared detailed instructions for physicians in the handling of emergency care of casualties and cooperates with the State Office of Civil Defense, county and city officials, and county medical societies in developing adequate programs to meet emergencies.

The Council on Medical Service has sponsored several state-wide health conferences dealing with rural health problems. It also provides direction of the health-safety program of the Wisconsin 4–H clubs and $200 in scholarships and awards for young people who are outstanding in their health achievements.

### Woman's Auxiliary to the State Medical Society

The Auxiliary is serviced to a considerable extent from the office of the State Medical Society. Advice and assistance are available to it, its records are maintained in the Society's office, a bulletin is prepared and distributed in cooperation with the Auxiliary editorial board, and special activities of the Auxiliary are provided with mechanical implementations through the Society's facilities. Of special significance to the doctors and the public are the Auxiliary's efforts in nurse recruitment and scholarships, encouraging the distribution of *Today's Health*, and arranging public meetings at which Medical Society activities and major health problems may be discussed.

### The History of Medicine

The accumulation and preservation of an adequate record of the development and progress of medicine in Wisconsin is a project assigned to the Society's Historical Committee. It seeks to preserve vital records, reports of activities and projects, and a wide variety of items reflecting the influence of the physician on public health. Its program receives the assistance of the State Historical Society and the Woman's Auxiliary to the State Medical Society.

### The Physician's Role in the Society

The strength of the State Medical Society of Wisconsin lies in its members and their county medical societies. The individual member should first be a competent, understanding practitioner. Second, he should be an active, conscientious citizen and participant in Medical Society affairs. His vote in the county society is the first step toward an effective voice in state and national medical policies.

The physician himself can determine how much he "gets" from the State Medical Society by knowing how to benefit fully from its many services. The suggestions and ideas of every member are always sought and considered. A wealth of information is available from the State Medical Society for the asking. Every member is always welcome at the Society headquarters. Visit 704 East Gorham Street in Madison at the next opportunity. Attend county and state medical meetings. Participate in the scientific sessions, but don't forget to visit the House of Delegates at Annual Meeting time. Every member is welcome to exercise his right and privilege of appearing before any reference committee of the House.

Be ready to make a contribution to medical progress and the health of the people. Also be ready to defend the profession. Criticism is healthy when it is based on knowledge—a fact as true when it comes from within the profession as from without. The State Medical Society of Wisconsin belongs to the physicians of Wisconsin. It is theirs to direct, to use, and to serve.

# Rehabilitation Services in Wisconsin

REHABILITATION services are available to eligible persons in Wisconsin through a program operated under the Rehabilitation Division of the State Board of Vocational and Adult Education. The program consists of special assistance to citizens who, because of physical or mental impairment, would either remain unemployable or would be employed at marginal pursuits.

Any person of working age is eligible for any necessary physical restoration services if he meets the following requirements:

1. He has a physical or mental defect which is a substantial employment handicap.
2. It is static, stationary, stable, or only slowly progressive. (Thus, acute illnesses and emergency cases are excluded.)
3. The disability can be removed or substantially reduced by treatment in a reasonable length of time.
4. He is unable to pay the full cost of the services out of his own resources.
5. The necessary services are not available from any other source.

Where eligibility and economic need are established, the following services can be provided: medical, psychiatric, and surgical examinations and treatment; hospitalization; convalescent care; dental care; nursing care; physical therapy; occupational therapy; speech therapy; prosthetic appliances; medical supplies; and drugs. Each applicant for vocational rehabilitation services is required to have a thorough medical examination before any services are provided. This examination usually is performed by his family physician and is financed by the state agency. In Wisconsin a committee of physicians advises the state agency regarding such matters of policy as professional standards, fee schedules, etc.

In providing service the Rehabilitation Division utilizes such public and private facilities as are available. In the medical area the Curative Workshops of Milwaukee, Green Bay, and Racine provide occupational and physical therapy, speech training, and other services. These workshops provide services on an outpatient basis only.

All patients are referred to the centers by the attending physician and are discharged by him upon completion of treatment. Physicians receive progress reports. Professional policies and practices are determined by medical advisory committees of the local medical societies.

The addresses of the workshops are as follows:

Curative Workshop of Green Bay, 1001 Cherry Street, Green Bay, Wisconsin.

Curative Workshop of Milwaukee, 750 North 18th Street, Milwaukee, Wisconsin.

Curative Workshop of Racine, 233 Northwestern, Racine, Wisconsin.

The only rehabilitation center in Wisconsin providing both inpatient and outpatient services is located in Madison and offers the following services:

*Wisconsin Neurological Foundation, Madison*

This is a 45-bed unit with private, semi-private, and ward rooms. There are facilities available for complete diagnostic and therapeutic management of neurologic patients; a department of physical medicine; facilities for psychologic testing, vocational counseling, occupational therapy, and recreation. The service is operated by physicians and dentists with an adequately trained staff.

Physicians interested in making these services available to their patients may contact the facilities directly or through the Vocational Rehabilitation Office nearest them. Rehabilitation service is offered through the Rehabilitation Division of the State Board of Vocational and Adult Education only to persons of employable age who meet the criteria outlined above. Following is a list of district and local offices, with the name and title of the person in charge:

*District 1*

Madison 3—Vocational School Building, 211 North Carroll Street, Room 458. Clare D. Rejahl, District Supervisor

Local Offices:

La Crosse—Vocational School—Carl J. Haase, Case Supervisor

Racine—828 Center Street—Virgil C. Bryan, Case Supervisor

*District 2*

Milwaukee 3—Vocational School Building, 1015 North Sixth Street, Room 222. Leslie A. Rumsey, District Supervisor

*District 3*

Green Bay—Vocational School Building, 200 South Broadway. Arthur W. Bouffard, District Supervisor

Local Office:

Wausau—Vocational School Building, Box 750—Levern J. Schultz, Case Supervisor

*District 4*

Eau Claire—8½ South Farwell Street. Melvin J. Chada, District Supervisor

Local Office:

Superior—917 Tower Avenue, Room 11—Herbert C. Ritzman, Case Supervisor

# The Revised Medical Practice Act

IMPORTANT fundamental improvements in the law which protects the people against unqualified practitioners in the health field have been accomplished during the last two sessions of the Wisconsin Legislature. Chapter 147 of the Wisconsin Statutes, referred to as the Medical Practice Act, has been both strengthened and modernized.

The Medical Practice Act defines the minimum qualifications required by the state of all practitioners from cultist to physician. It prescribes the make-up of the Board of Medical Examiners and outlines its functions and responsibilities. The Act sets forth the prerequisites for licensure, the method of making application, and the nature of the examinations in several of the practicing fields. Of equal importance, it spells out many of the medical crimes and provides the enforcement procedures and penalties.

Some provisions of the former Act dated back to Territorial days and were so antiquated as to be virtually meaningless in light of present-day medical education and practice. After several years of intensive study the State Medical Society offered to the Legislature its recommendations. For the most part those recommendations have been adopted.

Because of the importance and the extent of the legislative enactments which affect the Medical Practice Act, it is reprinted here in its entirety. The Wisconsin Statutes for 1953 have not been printed as of the time of this publication. Because the Revisor of Statutes has the final word on the organization of the Statutes and the several 1953 amendments are rather complex, it is possible that there may be slight variations between the text which follows and the text of the new Statutes when they appear. Every effort has been made to insure accuracy, however.

**147.01 Definitions.** (1) The "basic science law" is sections 147.01 to 147.12, inclusive, and as used therein:

(a) To "treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.

(b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts.

(c) The "basic sciences" are anatomy, physiology, pathology and physical diagnosis.

(d) The "board" is the state board of examiners in the basic sciences.

(2) Sections 147.01 to 147.12, inclusive, shall not apply to or affect persons making application for examination to hold a certificate, under chapter 152, as a dental hygienist nor shall the above sections apply to optometrists; provided further, that the exemption contained in this subsection shall likewise apply to all those who prior to July 1, 1952, file an application for a license to practice dentistry under the provisions of chapter 152.

**147.02 Practice.** No person shall treat, or attempt to treat, the sick unless he shall have a certificate of registration in the basic sciences, and shall have recorded the same with the county clerk in the manner provided in s. 147.14, and shall have complied with all other requirements of law. This section shall not affect the exemptions provided by subs. (1) and (2) of s. 147.19, nor shall it be construed to require a certificate of registration in the basic sciences for the practice of nursing by persons registered under chapter 149 nor for the practice of physical therapy by persons registered under s. 147.185.

**147.03 Board.** The governor, with the advice and consent of the senate, shall appoint the state board of examiners in the basic sciences. The board shall consist of 3 lay educators, none of whom shall be on the faculty of any department teaching methods of treating the sick. The term of office shall be 6 years. A vacancy shall be filled for the unexpired term. The board shall within 30 days of appointment organize by the election of a president, secretary and treasurer. The compensation of the members of the board shall be $10 for each day actually spent and actual and necessary expenses.

**147.04 Other boards.** No examining board for any branch of treating the sick shall admit to its examinations or license or register any applicant unless such applicant first present a certificate of registration in the basic sciences. Any such board may by rule accept such certificate in lieu of examination in those subjects.

**147.05 Application.** Application for a certificate of registration in the basic sciences shall be made to the board of examiners in the basic sciences, accompanied by sufficient and satisfactory evidence of good moral character and preliminary education equivalent to graduation from an accredited high school of this state, and a fee of ten dollars. If the applicant was on February 1, 1925, attending a professional school, high school education shall not be required.

**147.06 Examination.** Examination shall be in the basic sciences only, shall be conducted not less than 4 times a year at such times and places as the board shall fix, and shall be both written and by demonstration or other practical test. No applicant shall be required to disclose the professional school he may have attended or what system of treating the sick he intends to pursue. In lieu of its own examination, the board may accept, either in whole or in part, the certificate of the national board of

medical examiners provided that certification by the national board is accepted by the state board of medical examiners in whole or in part and that such certification is accepted by the basic science boards of at least 6 other states.

**147.07 Certificate.** If the candidate attains a grade of 75 per cent in each subject, he shall receive a certificate in the basic sciences, signed by the president and secretary. If he fails in one subject only, he may be re-examined in that subject at any examination within one year without further examination fee. If he fails in 2 or more subjects he must apply anew and stand examination in all subjects.

**147.08 Reciprocity.** The board may issue certificate to an applicant who presents sufficient and satisfactory evidence of having passed examinations in the basic sciences before a legal examining board or officer of another state, or of a foreign country, if the standards are as high as those of this state, and upon payment of a fee of fifteen dollars.

**147.09 Previous practice.** Any person who, on February 1, 1925, was regularly licensed or registered in the state of Wisconsin to treat the sick need not be registered under the basic science law. Any person who, on February 1, 1925, was not registered or licensed in the state of Wisconsin to treat the sick, but nevertheless on that date was lawfully engaged in this state in treating the sick, shall be registered upon presenting to the board, within sixty days after this section goes into effect, an application therefor, with sufficient and satisfactory evidence that he was, on such date, lawfully engaged in this state in treating the sick, and is of good moral character, and upon the payment of a registration fee of five dollars. The certificate shall recite registration solely as a person who, on February 1, 1925, was lawfully engaged in this state in treating the sick. Such certificate shall be in force only when filed with the county clerk in the manner provided in section 147.14.

**147.10 Revocation.** Certificate of registration in the basic sciences shall be subject to revocation for the causes and in the manner provided in section 147.20.

**147.11 Review.** The action of the board in granting or denying a certificate shall be subject to review by appeal in the manner provided in chapter 227, and any state examining board for any branch of treating the sick may take such appeal as a party aggrieved.

**147.12 Administration.** The board shall keep a complete record in which shall be entered all applications, examinations, registrations, fees, decisions, orders and proceedings. It shall from time to time from lists furnished by the state civil service commission, appoint such competent and recognized experts as shall be necessary to assist in the examinations, and necessary clerks. They shall receive such compensation as the board shall fix. On or before August first of each year, the board shall file with the governor a report of all receipts, disbursements and transactions for the preceding fiscal year. The disbursements of the board shall not exceed the fees received.

**147.13 Examiners.** (1) The Wisconsin state board of medical examiners shall consist of 8 members appointed by the governor, 7 of whom shall be licensed resident doctors of medicine and one of whom shall be a licensed resident doctor of osteopathy. The 7 doctors of medicine may, but need not, be selected from nominees of the state medical society and the doctor of osteopathy from nominees of the Wisconsin osteopathic association. The appointment of each member shall be for 4 years. No instructor, stockholder, member of, or person financially interested in any school, college or university having a medical department, or of any school of osteopathy, shall be eligible. Each member of the board shall be paid such compensation as the board determines, and, except for the secretary, not more than $15 per day, when actually and necessarily engaged in his duties. The secretary shall receive such compensation as the board determines, but not less than $1800 annually.

(2) The board shall hold its Annual Meeting on the second Tuesday of January at Madison, and it shall meet at least 3 other times during the year at such places as it determines. It shall elect annually at its January meeting a president, a vice president and a secretary-treasurer. The board shall maintain its office in Madison. The president, vice president or secretary-treasurer may administer oaths. The secretary-treasurer shall furnish such bond as the board shall require, and shall receive all moneys and pay the same into the state treasury.

(4) The board shall employ necessary assistants and fix their compensation.

(5) The board shall have a common seal, and keep a record of its proceedings and a register of applications, and licenses and certificates of registration issued. It shall make annual report of its proceedings to the governor on June thirtieth, including detailed statement of money received and expense of operation.

(6) The board shall investigate complaints of violation of this chapter, notify prosecuting officers, and institute proceedings.

**147.14 Practice.** (1) No person shall practice or attempt or hold himself out as authorized to practice medicine, surgery, or osteopathy, or any other system of treating the sick as the term "treat the sick" is defined in s. 147.01 (1) (a) without a license or certificate of registration from the state board of medical examiners, except as otherwise specifically provided by statute.

(2) (a) No person without a license or certificate or registration from the state board of medical examiners shall have the right to testify in a professional capacity on a subject relating to medical treatment, as a medical or osteopathic physician or practitioner of any other form or system of treating the sick, as defined in s. 147.01; provided that

a medical or osteopathic physician, licensed to practice in another state, may testify as the attending or examining physician or surgeon to the care, treatment, examination or condition of sick or injured persons whom he has treated in the ordinary course of his professional practice for the sickness or injury which is the subject of the judicial inquiry in any action or proceeding in which he is called as a witness.

(b) A court may permit any person to testify as an expert on a medical subject in any action or judicial proceeding where proof is offered satisfactory to the court that such person is qualified as such expert.

(c) A nonresident witness shall not be permitted to testify as an attending or examining physician and surgeon, or as an expert witness on a medical subject unless the party calling such witness has served on the opposing party a 5-day written notice in advance of calling such witness to testify, stating the name of such witness, his residence and business address. The court for good cause shown may shorten such notice to 3 days.

(3) No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under section 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M. D.," "D. O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick.

(4) No person shall practice medicine, surgery, or osteopathy, or any other system of treating bodily or mental ailments or injuries of human beings, under any other Christian or given name or any other surname than that under which he was originally licensed or registered to practice in this or any other state, in any instance in which the Wisconsin state board of medical examiners shall, after a hearing, find that practicing under such changed name operates to unfairly compete with another practitioner or to mislead the public as to identity or to otherwise result in detriment to the profession or the public. This subsection does not apply to a change of name resulting from marriage or divorce.

**147.15 Application.** Application may be made at the time and place designated by the board or at a regular meeting. Applicants for license to practice medicine and surgery shall present satisfactory evidence of good moral and professional character, and of having completed a preliminary education equivalent to graduation from an accredited high school of this state, and also a diploma from a reputable professional college. Applicants for license to practice medicine and surgery, shall present to the board a diploma from a reputable medical or osteopathic college with standards of education and training substantially equivalent to the university of Wisconsin medical school, approved and recognized by the board. Before approving and recognizing any such college or school, the board shall conduct an investigation and during the course thereof shall hold a public hearing with notice to all interested parties, at which any person may be heard. The board may designate an agent, including one or more board members, to conduct a portion or all of such investigation to determine the facts upon which the board shall make its findings. The findings and any action taken by the board with reference to approval or recognition of a school or college may be reviewed in the manner provided in ch. 227. The applicant shall present also satisfactory evidence of having completed a college course in physics, chemistry and biology, substantially equivalent to the premedical course at the university of Wisconsin, and if the professional college from which a diploma is presented does not require for graduation a hospital internship of at least 12 months in addition to a 4 years' course, a certificate of completion of such internship in a reputable medical or osteopathic hospital. Each applicant shall file a verified statement that he is familiar with the state health laws and the rules and regulations of the state board of health relating to communicable diseases. The application shall be accompanied by a fee, to be fixed by the board at not more than $40 and $5 additional for license if issued. An immigrant applicant shall present satisfactory evidence of having first citizenship papers, and if his professional education was completed in a foreign college, the application shall be accompanied by a fee of $75, and the further fee of $5 upon the issuance of license shall not be required. Applicants shall pay also the cost of translation into English by the board of documents and papers in a foreign language.

**147.151 Temporary educational certificates.** (1) Application for a temporary educational certificate may be made to the board by a person having training in medicine and surgery satisfactory to the board for purposes of this section. Such certificate shall entitle the holder to take postgraduate educational training in a teaching hospital which maintains standards for this training prescribed by the board, which standards shall be commensurate with those of nationally recognized accrediting organizations. Such certificate may be issued for a period not to exceed 1 year, and, in the discretion of the board, may be renewed annually for not more than 2 additional years. The fee for such certificate shall be fixed by the board at not more than $10 per annum, which amount shall also be paid for each renewal thereof. Not more than 25 such certificates shall be issued in any one year and no more than 75 shall be outstanding at any one time. The holder of such a certificate may, under the direction of a person licensed to practice medicine and surgery in this state, perform services requisite to the training authorized by this section. Acting under such direction, the holder of such certificate shall also have the right to prescribe drugs other than narcotics, and to sign any certificates, reports or other papers for the use of public authorities which are

required of or permitted to one licensed to practice medicine and surgery. The holder of such a certificate shall confine his training and practice within the hospital in which he is taking such postgraduate education. Neither he nor the hospital may receive any fees or other income for his services from any patients treated by him during the course of such training.

(2) The purpose of this section is solely to provide opportunities in this state for the postgraduate education of certain persons having training in medicine and surgery satisfactory to the board, without compliance with the licensure requirements of this chapter. Nothing herein contained shall be construed as changing in any respect the requirements for licensure to practice medicine and surgery in this state. The violation of the provisions hereof by the holder of such a certificate shall constitute cause for the revocation thereof.

**147.16 Examination.** Having complied with s. 147.15, the applicant shall be examined in medicine and surgery and further examined in the subjects taught in reputable professional colleges.

**147.17 License.** (1) If 6 members find the applicant for license qualified, it shall issue a license to practice medicine and surgery, signed by the president and secretary-treasurer and attested by the seal. Before granting a license by reciprocity, the board shall conduct an investigation in the manner provided in s. 147.15 to determine whether the requirements for licensure in the state in which the applicant for reciprocity is licensed are equivalent to those of this state. If it finds that the requirements in another state are equivalent to those of this state, the board may issue a license to practice medicine and surgery without written examination to a person holding a license to practice medicine and surgery, or osteopathy and surgery, in such other state, upon presentation of the license and a diploma from a reputable professional college approved and recognized by the board, or an honorably discharged surgeon of the armed services of the United States, or of the federal public health service, upon filing of a sworn and authenticated copy of his discharge; provided that such discharge was within one year of such application for license by reciprocity. In lieu of its own examination, the board may accept, either in whole or in part, the certificate of the national board of medical examiners. Fee for license with or without written examination shall be fixed by the board at not less than the reciprocity fee in the state whose license the applicant presents, and in no case less than $75. A person licensed before 1916 to practice osteopathy shall be licensed to practice surgery upon presenting satisfactory evidence of having completed a course in surgery at a reputable osteopathic college, requiring not less than 20 months' actual attendance, and the regular examination of the board in surgery, and being found qualified by 6 members. The board may deny the application of one not 21 years of age. No certificate of registration shall be considered equivalent to a license.

(3) A person licensed to practice osteopathy and surgery may apply to the board to be examined in materia medica and pharmacology as may be required by the board. Such applicants shall be given the same examination in materia medica and pharmacology as is given to applicants from medical colleges at any regular meeting of the board. Such application shall set forth the date such person was licensed to practice, the number of years and place or places in which he has practiced together with a statement from a reputable osteopathic college that applicant has successfully completed a refresher course approved by the board in materia medica and pharmacology consisting of not less than 64 hours of lectures and 60 hours of laboratory work while in actual attendance at such college; if the applicant shall be unsuccessful he may apply for re-examination at any subsequent meeting of the board. The application shall be accompanied by a fee of $20. Upon successfully passing such examination and payment of a fee of $5 and upon surrender of the old license the board shall issue a new license to practice medicine and surgery.

(4) Whenever the statutes authorize or require a practitioner of medicine to do or perform an act or to issue any statement, affidavit or certificate such statute shall be construed to include those practitioners of osteopathy and surgery who hold such new license to practice medicine and surgery.

(5) Sections 147.15 and 147.16 (as amended in 1949) and sections 147.17 (3) and (4) shall not be construed to abrogate the existing rights, privileges and immunities of any person licensed to practice osteopathy or osteopathy and surgery who do not hold a license to practice medicine and surgery.

(6) A license to practice medicine and surgery granted to an osteopathic applicant shall not authorize the holder to use the title of "doctor of medicine" nor the letters "M. D."

**147.175 Annual registration of physicians.** (1) Every person licensed to and engaged in or entering upon the practice of medicine and surgery, osteopathy, or osteopathy and surgery, in this state, shall, in the month of January of each year, register with the secretary of the state board of medical examiners, upon a form to be furnished by the board. The registration form, to be signed by each registrant, shall contain his name, his residence address, the name of the place and the address at which he is engaged in practice, and any other relevant information for the purpose of identifying the registrant which the board may prescribe. Persons licensed or relicensed in this state to practice medicine and surgery, osteopathy, or osteopathy and surgery, subsequent to January 31 of a given year shall register as required by the terms of this section within 30 days after being so licensed. The secretary-treasurer of the board, on or before December 1 of each year, shall mail or cause to be mailed to every person registered hereunder the registration form

above required. Each person registered hereunder shall display his proper registration certificate conspicuously in his office at all times.

(2) Each registrant shall pay for such registration a fee to be fixed by the Wisconsin state board of medical examiners for each given year, which fee shall not exceed $3 in any year; provided that those who register after January 31 of a given year, shall likewise pay whatever fee has been fixed for that year.

(3) On or before March 10 in each year the secretary-treasurer of the state board of medical examiners shall cause to be published and mailed to each person registered hereunder, a printed list of those so registered, which list shall be divided according to the branch of healing in which the registrant is licensed. The secretary-treasurer of the board shall also cause to be mailed a copy of such published list to the secretary of state, the district attorney of each county, each local board of health, the sheriff of each county, the chief of police of each community, and to any other public official who may request or have need thereof.

(4) Every registration made as provided in this section shall be presumptive evidence in all courts and other places that the person named therein is legally registered for the year covered by such registration.

(5) No registration shall be permitted by the secretary of the Wisconsin state board of medical examiners in the case of any person who has been found guilty of any of the unprofessional acts described in section 147.20, and upon conviction for any of said offenses, the registration of any such person shall be deemed automatically annulled upon receipt by the secretary of the board of a certified copy of the information, verdict and judgment, as provided in section 147.20 (3), subject to such registrant's right of appeal. A registrant whose license has been revoked and subsequently restored under the provisions of section 147.20 (4) shall be registered by the board upon tendering a certified copy of the order of the trial court restoring his license, together with an application for registration and the registration fee.

(6) The provisions of this section shall not be applicable to any physician while serving in the armed forces of the United States or of an allied government.

(7) If any subsection, paragraph or provision of this section, or its application to any person or circumstance shall be held unconstitutional, such decision shall not affect the constitutionality of any other subsection, paragraph or provision of this section or its application to other persons or circumstances.

**147.18 Itinerants.** Itinerant practitioners of medicine, surgery or osteopathy or of any form or system of treating the afflicted shall obtain an annual license in addition to the regular license or certificate of registration, and shall pay therefor two hundred fifty dollars per annum. Persons practicing medicine, surgery or osteopathy or professing or attempting to treat or heal ailments or injuries of the human body who go from place to place at regular or irregular intervals less frequently than once a week, are itinerant practitioners.

**147.185 Physical therapy.** (1) PRACTICE OF PHYSICAL THERAPY. (a) The practice of physical therapy is the treatment of disease as defined in s. 147.01 by the use of physical, chemical and other properties of heat or cold, light, water, electricity, massage, and therapeutic exercises, including posture and rehabilitation procedures, but the use of Roentgen rays and radium for any purposes, and the use of electricity for surgical purposes, including cauterization, are not included in the practice of physical therapy.

(b) No person shall practice or hold himself out as authorized to practice physical therapy, nor shall any person designate himself as a physical therapist, physiotherapist, physical therapy technician, or use the initial "P.T.," "P.T.T.," or "R.P.T." or any other letters, words, abbreviations, or insignia indicating that he is a physical therapist, without a certificate of registration issued by the board of medical examiners nor unless he practices under a prescription and the direct supervision of a person licensed to practice medicine and surgery. Nothing in this section shall prohibit any person licensed or registered, in this state, under another law, from engaging in the practice for which he is licensed or registered.

(2) APPLICATION. An applicant for a certificate of registration as a physical therapist shall file written application on forms provided by the board. The applicant shall present satisfactory evidence that he is at least 20 years of age, is of good moral character, has obtained a high school education or its equivalent, and has been graduated from a school of physical therapy with standards of education and training substantially equivalent to that of the University of Wisconsin. He shall pay to the board $15 and present himself for examination at the first meeting thereafter at which examinations are to be held.

(3) EXAMINATION. The examination shall be both scientific and practical in the applied sciences of anatomy, neuroanatomy, kinesiology, physiology, pathology, psychology, physics, physical therapy, as defined in this section, applied to medicine, neurology, orthopedics, pediatrics, psychiatry, surgery and medical ethics, technical procedure in the practice of physical therapy, and such other subjects as the board may determine to be necessary. The board shall select a state examining committee for physical therapy, and may do so from a list submitted by the Wisconsin chapter of the American physical therapy association, to assist it in carrying out the provisions of this section, which committee shall consist of 3 physical therapists who, after the initial appointment, shall be registered by the board and shall have had not less than 3 years of experience in the practice of physical therapy in this state

immediately preceding his appointment. The committee shall elect annually one of their members as president and another as secretary. They shall receive the same compensation and reimbursement as members of the board. The terms of office of the members first appointed shall continue for the following periods: one for 1 year, one for 2 years, and one for 3 years. Upon the expiration of such terms the board shall appoint a successor for a term of 3 years.

(4) CERTIFICATE. If the board finds the applicant qualified it shall issue a certificate of registration which shall expire on February 1 of each year and shall be renewed only upon application and the sending of a $3 annual renewal fee to the secretary of the state examining committee for physical therapy on or before January 31. Upon receipt of such application, the examining committee shall send the application and fee to the board for renewal. A renewal fee of $7 shall be paid by any physical therapist who seeks reregistration but who fails to renew his application on or before February 1 of any year. If the applicant has failed to renew his certificate for a period of at least 5 years, the board shall require the applicant to take a refresher course approved by the board before issuing a renewal certificate if after oral examination, the committee recommends to the board that such refresher course is necessary. If the applicant for reregistration has been guilty of conduct that would afford a ground for revocation under s. 147.20 the board may so find and refuse to reregister such applicant.

(5) REGISTRATION WITHOUT EXAMINATION. The board may issue a certificate of registration without examination to any person who applies on or before December 31, 1953, and who furnishes the board with sufficient and satisfactory evidence that, on the effective date of this section he had practiced physical therapy in this state and possesses the prerequisites for examination set forth in sub. (2). The board may issue a certificate of registration in physical therapy without examination to an applicant who presents evidence satisfactory to the board of having been licensed or certified as a physical therapist in another state or foreign country with standards determined by the board to be as high as those of this state. At the time of making such application the applicant shall pay a fee of $10. The board may also issue without examination a permit to practice physical therapy for not to exceed 6 months to any person who meets the qualifications of this section upon certification that he has been assigned to this state on a temporary basis to assist in a medical emergency and upon the payment of a $2 permit fee.

(6) PREVIOUS PRACTICE OF MASSAGE AND HYDROTHERAPY. Any person who, on the effective date of this section, is practicing massage and hydrotherapy in this state under a certificate of registration issued pursuant to the provisions of s. 147.185 as that section existed heretofore, shall have the right to continue so to practice under such certificate and the term "massage and hydrotherapy" shall be deemed to include the use of galvanic generator, diathermy, infra red ray, and ultra violet light for massage purposes. Nothing contained herein shall limit the existing authority of the board to revoke such certificate for cause, and in addition the board may require the holder of such certificate to demonstrate by examination his fitness to use the instrumentalities enumerated in this section. Lack of such fitness shall constitute cause for revocation of such certificate. No such certificate holder shall treat a specific disease except on the advice of a licensed medical physician.

(7) CHIROPRACTIC NOT AFFECTED. Nothing in this section shall be construed to restrict, inhibit or limit the practice of chiropractic as now practiced in Wisconsin, and as taught by accredited schools or colleges of chiropractic.

**147.19 Exceptions.** (1) Sections 147.14 to 147.18, shall not apply to commissioned surgeons of the army, navy, federal health service, or to medical or osteopathic physicians of other states or countries in actual consultation with resident licensed practitioners of this state, nor to the gratuitous prescribing and administering of family remedies or treatment rendered in an emergency.

(2) None of the provisions of this chapter or the laws of the state regulating the practice of medicine or healing shall be construed to interfere with the practice of Christian Science, nor shall any person who selects such treatment for the cure of disease be compelled to submit to any form of medical treatment.

**147.195 State medical grievance committee.** The state health officer, the president of the state board of medical examiners, and the attorney-general or deputy attorney-general are hereby constituted ex officio a state medical grievance committee, to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery under s. 147.17, that are inimical to the public health. The state health officer shall be chairman of the committee. Meetings of the committee shall be held at the call of the chairman. Any member thereof shall have power to subpœna and swear witnesses, and take evidence. The committee shall have the power to warn and to reprimand, when they find such practice, and to institute criminal action or action to revoke license when they find also probable cause therefor under criminal or revocation statute, and the attorney-general may aid the district attorney in the prosecution thereof. The records of said committee shall be kept by and be in the custody of the chairman thereof. No member of said committee shall receive any extra compensation therefor, nor other than his actual expenditures in attending upon his duties thereon. All divisions, officials and employes of state and local government are authorized to co-operate with the committee in conducting investigations and by making available to it pertinent data in their possession.

**147.20 Revocation.** (1) The words "immoral or unprofessional conduct" as used in this section mean: (a) Procuring, aiding or abetting a criminal abortion; (b) advertising in any manner either in his own name or under the name of another person or concern, actual or pretended, in any newspaper, pamphlet, circular, or other written or printed paper or document the curing of venereal diseases, the restoration of "lost manhood," the treatment and curing of private diseases peculiar to men or women, or the advertising or holding himself out to the public in any manner as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse or excessive indulgences, or in any diseases of a like nature or produced by a like cause, or the advertising of any medicine or any means whatever whereby the monthly periods of women can be regulated or the menses re-established, if suppressed, or being employed by or in the service of any person, or concern, actual or pretended so advertising; (c) the obtaining of any fee; or offering to accept a fee on the assurance or promise that a manifestly incurable disease can be or will be permanently cured; (d) wilfully betraying a professional secret; (e) indulging in the drug habit; (f) conviction of an offense involving moral turpitude; (g) engaging in conduct unbecoming a person licensed to practice or detrimental to the best interests of the public.

(2) Upon verified complaint in writing to the district attorney charging the holder of a license or certificate of registration from the state board of medical examiners or the state board of examiners in chiropractic with having been guilty of immoral or unprofessional conduct or with having procured his certificate or license by fraud or perjury, or through error, the district attorney shall bring civil action in the circuit court against the holder and in the name of the state as plaintiff to revoke the license or certificate. The court may appoint counsel to assist the district attorney and either party may demand a jury. No one shall be privileged from testifying fully or producing evidence, but he shall not be prosecuted or subject to penalty on account of anything about which he so does, except for perjury in so doing. If the court or the jury finds for the plaintiff, judgment shall be rendered revoking or suspending the license or certificate, and the clerk of the court shall file a certified copy of the judgment with the board of medical examiners or the state board of examiners in chiropractic, as the case may be. The costs shall be paid by the county, but if the court shall determine that the complaint made to the district attorney was wilful and malicious and without probable cause, it shall enter judgment against the person making the complaint for the costs of the action, and payment of the same may be enforced by execution against the body as in tort actions.

(3) When any person licensed or registered by the board of medical examiners is convicted of a crime committed in the course of his professional conduct, the clerk of the court shall file with the board of medical examiners a certified copy of the information and of the verdict and judgment, and upon such filing the board shall revoke or suspend the license or certificate. The board of medical examiners shall also revoke or suspend any such license or certificate upon satisfactory proof being made of the conviction of such license or certificate holder in a federal court of a crime committed in the course of his professional conduct. The action of the board in revoking or suspending such license or certificate may be reviewed in the manner provided in chapter 227.

(4) When a license or certificate is revoked no license or certificate shall be granted thereafter to such person. Any license or certificate heretofore or hereafter revoked may be restored by subsequent order of the trial court, but only after a first revocation, upon notice to the district attorney who prosecuted, or, in the event of his disability, his successor in office, upon written recommendation by the state board of medical examiners, and upon findings by the court that the applicant for restoration of license or certificate is presently of good moral and professional character and that justice demands the restoration.

(5) When a license or certificate is suspended, it shall be suspended for a definite term, but not to exceed 2 years. The authority suspending a license may restore it at any time when satisfied that justice demands the restoration.

(6) A license or certificate of registration may be voluntarily surrendered by its holder and shall be reissued by the board only when justice demands such reissuance. The action of the board may be reviewed in the manner provided in ch. 227.

**147.205 Injunction to enforce chapter 147.** (1) If it appears upon complaint to the board of medical examiners by any person or it is known to the board that any person is violating any of the provisions of chapter 147, except sections 147.24 and 147.25, the said board or the district attorney of the proper county may investigate and may, in addition to any other remedies, bring action in the name and on behalf of the state of Wisconsin against any such person to enjoin such person from such violation or violations of this chapter.

(2) If it appears upon complaint to the board of examiners in chiropractic by any person or it is known to the board that any person is violating any of the provisions of sections 147.23, 147.24 and 147.25, the said board or the district attorney of the proper county may investigate and may, in addition to any other remedies, bring action in the name of and on behalf of the state of Wisconsin against any such person to enjoin such person from such violation or violations.

**147.206 Midwifery.** Any person who, on the effective date of this section, is practicing midwifery in this state under a certificate of registration issued him by the board may continue so to practice under

such certificate but subject to the provisions of ch. 150 of the 1951 statutes as in effect prior to the effective date of this section and subject to the other provisions of this chapter.

**147.21 Penalty.** Anyone violating any provision of this chapter shall be fined not less than one hundred nor more than five hundred dollars, or imprisoned not less than sixty days nor more than one year, or both.

**147.22 Malpractice.** Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the afflicted without having a license or a certificate of registration authorizing him so to do, shall be liable to the penalties and liabilities for malpractice; and ignorance on his part shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners.

**147.23 Chiropractic regulated.** (1) No person shall practice chiropractic, or in any manner attempt or hold himself out to do so, unless he have a certificate of registration in the basic sciences and a license to practice chiropractic from the state board of examiners in chiropractic, and shall have recorded such certificate and license with the county clerk of any county in which he shall so practice or attempt or hold out to practice, and pay a fee of fifty cents for each recording.

(2) The governor, with the advice and consent of the senate, shall appoint the state board of examiners in chiropractic to consist of three chiropractors, each of whom shall have been a continuous resident of and practitioner of chiropractic in the state for the preceding three years, who is not an officer or employer, nor financially interested in any school or college of chiropractic, and who shall not be graduate of any school teaching a method of treating the sick other than chiropractic. The term of office shall be six years, and a vacancy shall be filled for the unexpired term. The first appointments shall be made within thirty days after the taking effect of this section, and shall be for terms expiring April 1, 1927, April 1, 1929, and April 1, 1931, respectively. The board shall within thirty days after appointment organize by the election of a chairman and secretary. The compensation of the members of the board shall be ten dollars for each day actually spent and actual and necessary expenses incurred in the performance of their official duties.

(3) Application for a license to practice chiropractic shall be made to the board of examiners in chiropractic, accompanied by sufficient and satisfactory evidence of good moral character, preliminary education equivalent to graduation from an accredited high school of this state, graduation from a reputable school of chiropractic, approved and recognized by the board of examiners in chiropractic, having a residence course of not less than 36 months, consisting of not less than 3,600 60-minute class periods, certificate of registration in the basic sciences, and a fee of $25. An applicant for a license who was regularly enrolled in and attending a reputable and approved school of chiropractic prior to June 1, 1947, or who graduated therefrom prior to that date, shall, if otherwise qualified, be examined on the basis of the requirements of this section as they existed prior to July 27, 1947.

(4) Examination shall be in the subjects usually taught in such reputable schools of chiropractic, and shall be conducted at least twice a year at such times and places as the board shall determine.

(5) The board shall grant without examination a license to practice chiropractic in this state to any person who was on February 1, 1925, a reputable practitioner of chiropractic in this state, and who shall present to the board of examiners in chiropractic, prior to September 1, 1925, sufficient and satisfactory evidence of the same.

(7) All licenses issued by the board shall expire on the thirty-first day of December following the issue thereof, except that any holder of a license may have the same renewed from year to year by the payment of an annual fee of $8.

(8) The board shall keep a complete record of all applications, examinations, licenses, fees and proceedings. On or before August first of each year, the board shall file with the governor a report of all receipts, disbursements and transactions of the preceding fiscal year.

(9) No person shall practice chiropractic in this state under any other Christian or given name or any other surname than that under which he was originally licensed or registered to practice chiropractic in this or any other state in any instance in which board of examiners in chiropractic shall, after a hearing, find that practicing under such changed name operates to unfairly compete with another practitioner or to mislead the public as to identity or to otherwise result in detriment to the profession or the public. This subsection does not apply to a change of name resulting from marriage or divorce.

**147.24 License revocation or suspension.** The board of examiners in chiropractic, by order, may deny, suspend or revoke any license or certificate of registration if the licensee or registrant:

(1) Obtained the license or certificate through error or fraud;

(2) Is habitually drunk or addicted to the use of habit-forming drugs;

(3) Is hereafter convicted in a court of competent jurisdiction, either within or without this state, or in federal court, of any violation of any law governing the practice of chiropractic or of any felony, a certified copy of the record of conviction to be conclusive evidence of such conviction;

(4) Has obtained or sought to obtain anything of value by fraudulent representation in the practice of chiropractic;

(5) Is guilty of immoral or unprofessional conduct;

(6) Has continued practice, knowingly having an infectious or contagious disease; or

(7) If the applicant or registrant maintains a professional connection or association with any other person continuing to violate the provisions of this chapter after 10 days' notice in writing by the board.

(8) The board may without further process revoke the license of one who fails to annually register and pay the fee within 60 days after written notice, mailed to his last known address by registered mail. His license may be reinstated, in the discretion of the board, by the payment of $25 within one year from revocation. If application for reinstatement is not made within a period of one year from revocation he may be required to demonstrate that he is still qualified to practice by taking an examination in such chiropractic subjects as may be required by the board. The fee for such examination and reinstatement of license shall be $50.

**147.25 Unprofessional conduct.** Unprofessional conduct shall include, without limitation because of enumeration:

(1) Any conduct of a character likely to deceive or defraud the public;

(2) Loaning of a chiropractic license or certificate to anyone;

(3) Employment of "cappers" or "steerers" to obtain chiropractic business, or any public solicitation of chiropractic patronage;

(4) Splitting or dividing any fee for chiropractic service with any person except an associate licensed chiropractor;

(5) Use of unprofessional advertising which shall include without limitation because of enumeration:

(a) Any advertising statement of a character tending to deceive or mislead the public;

(b) Advertising professional superiority or performance of professional services in a superior manner;

(c) Advertising fixed prices for variable services;

(d) Using advertising solicitors or press agents;

(e) Use of office signs which contain wording other than the names of duly licensed chiropractors practicing therein, office hours and purely educational matter not in conflict with law;

(f) Use of printed advertisements which contain wording of other than names of duly licensed chiropractors, office hours, location, telephone numbers and educational matter not in conflict with law.

**147.26 Procedure for hearings.** (1) The board may make investigations and conduct hearings in regard to the conduct of any licensed chiropractor who, it has reason to believe, is acting or has acted in violation of section 147.24 or 147.25. The chairman or secretary of the board may administer oaths and issue subpoenas for attendance of witnesses and take testimony under oath. The person complained against shall have notice in writing of the charges, specifying a date of not less than 10 days after service thereof for a hearing and shall have opportunity to confront witnesses and produce testimony. A stenographic record of the proceedings shall be taken and a transcript made for the board's files. The person complained against may within 60 days after notice in writing to the board's action mailed to his last-known address, by registered mail, proceed to review any action of the board as provided in chapter 227.

(2) Upon application and satisfactory proof that the cause of such revocation or suspension no longer exists, the board, in its discretion, may reinstate any license or registration by it suspended or revoked.

## EPILEPTICS AND THE STATE MOTOR VEHICLE DEPARTMENT

No one who is subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin, except under the following conditions:

If an epileptic is under medical care, however, and while under medication is free from seizures, and his driving is not otherwise a hazard to public safety, he may be issued a temporary license, which must be recertified each six months. Section 85.08 (6) (j) of the Wisconsin Statutes, enacted during the 1949 session of the Legislature, provides that any physician licensed in this state may recommend such a temporary license for a patient on a combined questionnaire and recommendation form provided by the Motor Vehicle Department.

The issuance of a temporary license, predicated upon such a recommendation by the physician rendering treatment, is discretionary with the Motor Vehicle Department, but a denial may be reviewed by a special board, two of the three members of which are designated by the president of the State Board of Health.

# Discarding Case Records and X-Rays

HOW long should you retain your case records after professional services to your patient have ended? When can you safely discard roentgenograms? As records accumulate through the years and storage becomes an increasing problem, these questions become ever more important.

Professional records of physicians are generally considered to be the property of the physician who makes them. There are limitations upon this property right, of course. Professional case records are held by the physician subject to the right in the patient that they be kept confidential. Ethical considerations require that they be made available to a succeeding physician upon the request of the patient.

Subject to those limitations, the physician has a clear property right in his professional records and x-rays. His legal right to destroy them in the absence of statutory restriction follows from his ownership of them. As a matter of professional judgment, however, such records should not be destroyed so long as they have any conceivable value either to the physician or to the patient. It is suggested that each record, then, be individually evaluated before destruction.

State and federal narcotic laws require physicians to retain narcotic records for specified periods of time, usually two years. Severe penalties, including revocation of narcotic licenses, may be imposed for failure to comply with this requirement.

Certainly professional records should be kept as long as they may be of value to the physician or his successor in the treatment of the patient at subsequent times. This is, of course, a moral rather than a legal requirement. It is clear, however, that there are many situations in which a premature destruction of professional records and x-rays could operate as a disservice to the patient and could result in great harm.

Professional records should be retained over the period of time in which the physician's treatment and diagnosis may be a matter of concern to the patient in the prosecution or defense of a legal action or in the establishment of some legal right. The establishment of a service-connected disability in a claim against the Veterans Administration, the determination of mental capacity in a will contest, the evaluation of personal injuries in an automobile accident, the extent of disability resulting from an industrial accident in a claim under the Workmen's Compensation Act, are examples of legal actions in which professional records are of substantial importance to the patient.

The controlling considerations in determining how long professional records should be retained for these purposes are the statutes of limitations fixing the time in which legal action must be brought. Mental incapacity, infancy, and various other factors may enlarge this time, however. It is therefore recommended that if the physician has any reason to suspect that professional records may have legal value to the patient, he consult the patient before destroying them.

The importance of records in the defense of malpractice claims cannot be overemphasized. Professional records and x-rays should be preserved over the period of time necessary to protect the attending physician and the hospital if it is involved, insofar as any claim for malpractice may be concerned. Wisconsin statutes require that one alleging a claim of malpractice must assert that claim either by institution of legal action or by the filing of a formal notice with the physician in a manner prescribed by statute within two years of the occurrence of the alleged event. This applies even to those who may be incapacitated by reason of infancy or insanity.

Even where no suit has been filed or notice given within two years, the patient may still raise the matter of malpractice as a defense to an action by the physician to collect fees. Such a collection action must be commenced within six years and, thus, if the physician considers that it may be necessary to resort to legal action in the collection of his fee, it would be well to retain his professional records for at least that six-year period.

It is apparent from the above that no general statement can be made as to the length of time professional records should be kept. In the absence of statutes such as the narcotic laws, the obligation of a physician to preserve his records appears to be a moral rather than a legal one, and he incurs no liability as such for failing to keep them. Certainly, however, it is clear that the welfare of both the physician and his patient is best served if careful consideration is given each case record before destruction.

# Dangerous Drug Law

**151.07 Dangerous drugs.** (1) As used in this section, unless the context otherwise requires:

(a) "Dangerous drug" means any drug unsafe for self-medication and shall be limited at the time of the effective date of this act [July 26, 1947] to include:

1. Barbiturates, the salts and derivatives of barbituric acid, also known as malonylurea, having hypnotic or somnifacient action, and compounds, preparations and mixtures thereof.

2. Sulfonamides or derivatives, compounds or mixtures thereof.

3. Thyroid and its contained or derived active compounds or mixtures thereof.

4. Cinchophen, neocinchophen, or compounds or mixtures thereof.

5. Aminopyrine, or compounds or mixtures thereof.

6. Amphetamine, desoxyephedrine, or compounds or mixtures thereof, except preparations for use in the nose and unfit for internal use.

7. Diethyl-stilbestrol, or compounds or mixtures thereof.

8. Ergot, cotton root or their contained or derived active compounds or mixtures thereof.

9. No compound, mixture, or preparation shall be deemed a dangerous drug if, in the case of barbiturates, it contains a sufficient quantity of another drug or drugs in addition to the salts or derivatives to cause it to produce an action other than its hypnotic or somnifacient action, or if it is intended for use as a spray or gargle or for external application and contains, in addition to such salts or derivatives some other drug or drugs rendering it unfit for internal administration. No compound, mixture or preparation shall be deemed a dangerous drug if it is designed for the purpose of treating animals or poultry and so labeled.

(b) "Delivery" means selling, dispensing, giving away or supplying in any other manner.

(c) "Patient" means the individual for whom dangerous drugs are prescribed or to whom dangerous drugs are administered.

(d) "Person" includes an individual, corporation, partnership or association.

(e) "Practitioner" means a person licensed by law to prescribe and administer dangerous drugs.

(f) "Pharmacist" means a person duly registered with the state board of pharmacy as a compounder, dispenser and supplier of drugs.

(g) "Prescription" means a written order or an oral order later reduced to writing by a practitioner for a dangerous drug for a particular patient, which specifies the date of its issue, the name and address of such practitioner, the name and address of the patient, the name and quantity of the dangerous drug prescribed, directions for use of such drug and, in case of a written order, the signature of such practitioner.

(h) "Manufacturer" means persons other than pharmacists who manufacture dangerous drugs, and includes persons who prepare such drugs in dosage forms by mixing, compounding, encapsulating, entableting, or other process.

(i) "Wholesaler" means persons engaged in the business of distributing dangerous drugs to persons included in any of the classes named in subsection (8).

(j) "Warehouseman" means persons who store dangerous drugs for others and who have no control over the disposition of such dangerous drugs except for the purpose of such storage.

(2) No person except a practitioner shall deliver any dangerous drug except upon the prescription of a practitioner. An oral prescription, by telephone or otherwise shall be promptly reduced to writing and filed by the pharmacist.

(3) No person, except a registered pharmacist or a practitioner shall prepare, compound, dispense or prepare for delivery for a patient any dangerous drug.

(4) No dangerous drug shall be delivered unless there is affixed to the immediate container a label disclosing:

(a) The name and address of the owner of the establishment from which such drug was delivered.

(b) The date on which the prescription for such drug was filled.

(c) The number of such prescription as filed in the prescription file of the pharmacist who filled such prescription.

(d) The name of the practitioner who prescribed such drug.

(e) The name and address of the patient.

(f) Directions for use of the drug as contained in the prescription.

(5) No prescription for a dangerous drug shall be refilled except as designated on such prescription, and unless accurate record of such refilling is entered on such prescription showing the date and amount thereof. No oral or written prescription shall be refilled unless the provisions of 151.07 (2) have been first complied with and unless either written or oral authority has been given by the prescriber.

(7) It shall be unlawful for any person to have any dangerous drug in his possession unless such drug was obtained in compliance with the provisions hereof.

(8) The provisions of subsections (2), (3), (4) and (7) shall not be applicable to the wholesale delivery of dangerous drugs to persons included in any of the classes hereinafter named; nor to the agents or employes of such persons for use in the usual course of their business or practice or in the performance of their official duties, as the case may be; nor to the possession of dangerous drugs by such persons or their agents or employes for such use:

(a) Pharmacists.

(b) Practitioners.

(c) Persons who procure dangerous drugs for the purpose of lawful research, teaching or testing and not for resale.

(d) Hospitals and other institutions which procure dangerous drugs for lawful administration by practitioners.

(e) Officers or employes of the federal government or state or local governments.

(f) Manufacturers and wholesalers.

(9) The state board of pharmacy is hereby authorized to promulgate necessary regulations for administration and enforcement of this section.

(10) Any person who violates any provision of this section shall be imprisoned not more than one year or fined not more than $500, or both; but if a further violation is committed after a conviction of such person under this section has become final, such person shall be imprisoned not more than 2 years or fined not more than $1,000, or both.

(11) If any provision of this section is declared unconstitutional or the applicability thereof to any person or circumstances is held invalid, the constitutionality of the remainder of the section and the applicability thereof to other persons or circumstances shall not be affected thereby.

## TAX DEDUCTIONS FOR HEALTH EXPENSES

Following is a summary of the principal provisions of the state and federal income tax laws relating to the deductibility of health expenses of the tax payer and his immediate family.

1. *Federal Law.* Among the items deductible are medical, dental, drug, nursing, hospital, x-rays, travel directly related to hospitalization, including, in the case of a helpless patient the travel expenses of a parent or another companion. "Premiums for insurance policies which pay hospital, surgical, medical, and related benefits are likewise deductible, as is that portion of the total premium of a health and accident policy which represents such benefits. Premiums for disability or time loss insurance, and for accidental death and dismemberment, are *not* deductible, however." To be deductible, *such expenses must be actually paid,* not merely incurred during the tax year.

Only those health expenses in excess of 5 per cent of the tax payer's adjusted gross income may be deducted. Such expenses are *not* allowable up to an amount equal to 5 per cent of such adjusted gross income. For maximum health deductions and fuller treatment of this subject in the federal statute see the *Wisconsin Medical Journal,* December 1953, page 642.

2. *Wisconsin Law.* Medical, surgical, dental, hospital, nursing, and other healing services and the cost of drugs and medical supplies incurred by the tax payer on account of sickness or of personal injury to himself or his dependents are deductible *if paid* during the tax year, for total amounts in excess of $75.00, but not exceeding $1,500.00. In other words, the first $75.00 of health expenses of a Wisconsin income tax payer and his dependents is not allowable, nor is any excess of such expenses over $1,500.00. The Wisconsin law expressly allows health and accident insurance premiums to be deducted as medical expenses. This point is also to be found in the income tax article in the *Wisconsin Medical Journal,* December, 1953, page 642.

# State Hospital Agency Renders Unique Services

By VINCENT F. OTIS*
Madison

AMONG the newer agencies in state government is the Division of Hospital and Related Services within the State Board of Health. Created by the 1947 session of the legislature to administer the Hill–Burton federal grants-in-aid program of hospital construction, the division soon became the clearing agency for rendering a highly specialized service to communities planning new or additional hospital facilities.

In its desire to promote efficiency in the over-all hospital field for the people of Wisconsin, the Board of Health consolidated and concentrated all matters pertaining to hospitals and related institutions in one place, the Division of Hospital and Related Services. In addition to the hospital construction program, the division administers the licensure of maternity hospitals, nursing homes, and homes for the aged, as well as general hospitals. With the assistance of advisory councils and committees, standards pertaining to these institutions are developed and enforced. Visits to such institutions to determine adherence to standards of operation offer a real opportunity not only to become thoroughly acquainted with problems at the grass roots level, but also to enable state consultants to provide an educational service of a practical nature to the hospitals and communities. The assimilation in one place of state-wide information about problems and their solutions, large and small, complex or foreign to one area of the state, makes it possible to exchange such valuable findings with others confronted with similar situations.

Because communities build new hospitals or expand existing ones at intervals of ten, twenty, or thirty years, information is usually lacking at the local level concerning the technical phases of surveying, planning, and construction problems. Gathering all such needed facts to plan a functionally sound facility and to avoid costly mistakes—mistakes which sometimes remain visible during the life of the finished structure—is probably more important than merely constructing a building. The completed structure will reflect the ability of the individuals furnishing the consultation during the planning stages. That is why it is so extremely important to spend more time on surveying the needs and planning the facility.

The technical staff in the Division of Hospital and Related Services is prepared to offer consultation covering the more important aspects of providing adequate hospital facilities. Among the many activities of the division are:

1. **Surveys of hospital bed needs.** A survey of actual bed needs must be completed early in the planning stage. Current information is readily available in the state hospital plan about every hospital service area. Hospital study committees should obtain, among other needed data, answers to such questions as:

   (a) What facilities are now available to the community?

   (b) Can present hospitals be better utilized before any expansions are planned?

   (c) Are the existing hospitals adequately staffed and operated?

   (d) How large a trading area should the hospital service?

2. **Giving information on how to dispose of replaceable facilities.** A few proprietary hospitals remain in existence (less than three per cent of all general hospital beds) and these are gradually being replaced with new fire-resistive, community-owned hospitals. Information is available on how other communities have disposed of such facilities, usually inadequate, to the satisfaction of all interested parties. Community-owned hospitals are supported much more readily than institutions owned by private interests.

3. **Guidance in selecting the hospital site.** Such factors as (a) location and accessibility, (b) nuisances, (c) public utilities, (d) dimensions of site, (e) orientation and exposures, (f) topography and subsoil conditions must all be known before deciding on the site.

4. **Planning the hospital.** The size and location of such departments as the obstetrical, surgical, medical, and pediatric units and their integration with central service facilities are always a problem, particularly in the community where expansion is certain within the next decade. Statistics on population trends and hospital utilization are readily available through the division.

5. **Doctors' clinics or hospitals?** Not every community needs a hospital. This is particularly true of small communities within a reasonable distance of existing acceptable facilities. If the community is small, the possibility of building a clinic for physicians and surgeons should be considered. The clinic might be planned to include offices for one or more doctors and perhaps a dentist. It could have laboratory and x-ray facilities and other minimal equipment for emergencies. The use of quick, effective ambulance service to transport patients to nearby hospitals to provide hospital and medical

* Director, Division of Hospital and Related Services, Wisconsin State Board of Health.

care beyond the emergency stage and to make possible more specialized services is preferable to a duplication of costly facilities.

### Consultation Services for Hospitals

The division provides a staff of qualified consultants in nursing, dietetics, public health engineering, financing and accounting, and hospital administration. These services are available for the most part to communities upon specific request; however, due to the limited staff, requests for these services are complied with on a priority basis with preference given to communities having the most pressing problems.

## SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1953, the March of Medicine began its eighth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 40 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

| *Station* | *City* | *Time* | |
|---|---|---|---|
| WHBY | Appleton | Saturday | 8:30 a.m. |
| WATW | Ashland | Saturday | 8:15 a.m. |
| WHSA | Brule | Saturday | 10:30 a.m. |
| WHKW | Chilton | Saturday | 10:30 a.m. |
| WHWC | Colfax | Saturday | 10:30 a.m. |
| WHAD | Delafield | Saturday | 10:30 a.m. |
| WEAU | Eau Claire | Saturday | 1:30 p.m. |
| KFIZ | Fond du Lac | Saturday | 8:30 a.m. |
| WBAY | Green Bay | Saturday | 3:15 p.m. |
| WHHI | Highland | Saturday | 10:30 a.m. |
| WJMS | Ironwood, Michigan | Saturday | 8:15 a.m. |
| WLIP | Kenosha | Saturday | 11:15 a.m. |
| WKBH | La Crosse | Saturday | 11:00 a.m. |
| WLDY | Ladysmith | Saturday | 11:00 a.m. |
| WHA | Madison | Saturday | 10:30 a.m. |
| WIBA | Madison | Saturday | 9:00 a.m. |
| WOMT | Manitowoc | Saturday | 9:15 a.m. |
| WMAM | Marinette | Saturday | 11:45 a.m. |
| WDLB | Marshfield | Saturday | 10:45 a.m. |
| WIGM | Medford | Saturday | 10:15 a.m. |
| WCAN | Milwaukee | Sunday | 6:45 p.m. |
| WEKZ | Monroe | Friday | 2:00 p.m. |
| WNAM | Neenah | Wednesday | 8:45 a.m. |
| WOSH | Oshkosh | Saturday | 11:00 a.m. |
| WPFP | Park Falls | Saturday | 10:45 a.m. |
| WIBU | Poynette | Thursday | 2:30 p.m. |
| WPRE | Prairie du Chien | Saturday | 10:15 a.m. |
| WRJN | Racine | Sunday | 5:45 p.m. |
| KAAA | Red Wing, Minnesota | Monday | 9:15 a.m. |
| WRDB | Reedsburg | Monday | 4:15 p.m. |
| WOBT | Rhinelander | Saturday | 9:15 a.m. |
| WHRM | Rib Mountain | Saturday | 10:30 a.m. |
| WJMC | Rice Lake | Saturday | 10:00 a.m. |
| WRCO | Richland Center | Wednesday | 3:30 p.m. |
| WTCH | Shawano | Sunday | 6:45 p.m. |
| WHBL | Sheboygan | Tuesday | 7:15 p.m. |
| WLBL | Stevens Point | Saturday | 10:30 a.m. |
| WDOR | Sturgeon Bay | Thursday | 9:15 a.m. |
| WDSM | Superior | Saturday | 10:15 a.m. |
| WSAU | Wausau | Monday | 4:15 p.m. |
| WBKV | West Bend | Saturday | 11:00 a.m. |
| WHLA | West Salem | Saturday | 10:30 a.m. |

# Medical Partnerships

## Introduction

WHEN two or more physicians decide to be associated with one another, such association takes one of three forms. Under one form, one of the physicians, usually the older, employs one or more other physicians on a salary, or a combined salary and bonus basis. A second form of association is one under which two or more physicians share the reception room and laboratory facilities, as well as clerical staffs, on an agreed basis, but each retains the full earnings of his professional practice. The third, and most intimate form of professional association, is the partnership. Under such an arrangement, two or more physicians agree to share the profits and losses and the other ups and downs of their pooled professional efforts.

Practice in the form of a corporation has been excluded from consideration here because of the well established legal principle that a corporation cannot practice medicine. Accordingly, a corporate organization in the medical field usually is limited to the ownership of land, building, and equipment which may be leased or otherwise made available to two or more physicians. Those complications represent a separate subject which does not properly fall within the scope of this article.

## Nature of Partnership; Some Disadvantages

A partnership is one of the closest forms of personal and legal association which exists. On the legal side, inasmuch as each partner is held by law to be an agent of the partnership, he may bind the partnership by his actions, which is another way of saying that he may bind all other partners. That is especially true of a state like Wisconsin, which does not regard the partnership as possessing legal entity or personality, such as characterizes a corporation. The law of this state regards a partnership as nothing more than an aggregation of two or more persons. Such action by one partner may be nothing more than the decision to subscribe to a magazine or to purchase a new piece of equipment. In another situation it may also involve his partners in alleged liability for negligence in the treatment of a patient.

Further, the partnership assets are subject to the rights of the creditors of each partner for obligations incurred by that partner in the conduct of partnership's activities. Such creditors, having established their rights, may proceed against the full partnership assets should that be necessary to satisfy such rights.

Clearly, there are substantial professional personal and financial risks implicit in the partnership relationship.

## Some Advantages of a Partnership

One of the principal advantages of a partnership is that it permits the pooling of professional skills, of separate backgrounds, and of the power of different types of men to attract patients. In the practical financial aspect, a partnership permits the pooling of capital. It also serves as a cushion against losses to have one or more persons share those losses. Where all but the owner of a practice are on a salary basis, such owner has to carry losses alone.

A further marked advantage of a partnership arrangement is the relatively greater stability of professional practice which this type of association makes possible. Not only is consultation likely to be freer while all partners are there, but there is greater likelihood of continuity when a partner is absent for any cause, or when he retires or dies. This factor of continuity is advantageous alike to the patient and physician. A partnership can build its practice at certain standards with greater assurance than is probably possible in other types of association, that such standards will be continued during the absence or following the withdrawal or death of one or more partners.

On the economic side, disposition of a practice can be more flexibly arranged through a partnership than through other means. The conclusion seems warranted that the reasonably assured advantages of a partnership substantially outweigh its potential disadvantages.

## Establishment of a Partnership

A partnership may in fact exist by consent and understanding between the partners, even though the fact is not known to the general public. It may also exist by oral understanding, or by operation of law, even where there is no formal agreement. The first arrangement might have possible ethical considerations. The second type is clearly imprudent on tax and other financial grounds. Every partnership between professional men for the open practice of their profession on an association basis should be openly and publicly declared. Further, every such association should, for the protection of the parties during life, and for the protection of their estates and families on death, be formalized in a written contract.

## Advantages of a Written Partnership Agreement

It is entirely possible for two reasonable individuals who are dealing with each other on a verbal basis to misunderstand each other. No contract can be written which will cover all situations. or remove all such possibilities. Areas of potential misunderstanding can be greatly reduced, however, when the intention of the parties on basic matters

is put in writing. Such questions as name and the right of its continuing use; the inclusion or exclusion of such intangible factors as good will; the valuation of tangible assets and of accounts receivable, either of which may vary substantially from those shown on the partnership books; the share of each partner in the capital of the partnership; the share of each partner in the gains or losses of the partnership, which again, may vary substantially from his capital investment, all these, and many other points may be covered, and are ordinarily settled by a competently drafted partnership agreement.

### Termination of Partnership

Ordinarily, a partnership between physicians is dissolved on the withdrawal or death of any of the partners. A partnership agreement may provide, however, for the continuation of a partnership in either contingency. Thus, the retired partner may continue to enjoy the fruits of his efforts on at least a limited basis during the period required for collecting his accounts and winding up his interest.

In like manner, the widow and children of a deceased partner may, through contract made while the physician was alive, avoid the disadvantage of a forced liquidation. This ordinarily will permit a greater total payment to the retired physician, or to the heirs of a deceased physician, than is possible from an immediate sale or other liquidation of his interest. It also permits a substantial tax saving to the surviving partners under the present provisions of the federal income tax law.

The tax advantage above mentioned has a rather technical basis which can be summarized with substantial accuracy as follows: Where a partnership agreement makes no provision for the sale of the interest of a retired or deceased partner, the purchase of such interest by the remaining partners is not deductible by them for income tax purposes, but has to be capitalized. Only those portions of such capital investment as are depreciable can be written off during the useful life of such assets.

On the other hand, where an inactive or deceased partner has a continuing participation in the net income of a partnership for an agreed period, such income is reportable and taxable as to him or his heirs as ordinary income, rather than as capital gain or loss. All such payments are *deductible* from the net partnership income of the remaining active partners. Generally speaking, the inactive partner or his heirs suffer no substantial tax disadvantage under such an arrangement; whereas, the living partners enjoy a substantial tax advantage by reason of which they can pay more for such interest than would otherwise be the case.

### Tax Savings of Fiscal Year Partnership

Upon creation of a partnership or the admission of a new partner to a firm, substantial federal income taxes can be saved through the device of adopting a partnership fiscal year not coinciding with the calendar year. Such a device allows savings of taxes on up to eleven months' income.

The device is perhaps best illustrated with an example. Assume that the share of Doctor A in net partnership profits for a twelve month period is $30,000, or $2,500 monthly. If the medical partnership's fiscal year coincides with the calendar year, Doctor A must report $30,000 on his personal income tax return for that year.

If, upon admission of a new partner, or upon formation of a partnership by sole practitioners, effective July 1, 1954, the new partnership agreement provides that the partnership fiscal year is to run from July 1, 1954, to January 31, 1955, and thereafter from February 1 to January 31, doctor A would need to report on his 1954 federal income tax return only his professional income for the first six months of 1954, or $15,000. In 1955, he would report only the professional income for the last six months of 1954 and the first month of 1955, or $17,500. For years 1956 and thereafter, twelve months of income would be reportable. However, Doctor A has succeeded in getting eleven months behind in reporting his income. He need never catch up at time of dissolution of the partnership, or upon his death, retirement, or withdrawal if the partnership agreement is properly drawn.

In the above example, assuming no other income and assuming Doctor A is married and has two children, his net saving in federal income taxes for the years 1954 and 1955 is about $10,000.

### Basic Provisions of a Partnership Agreement

Following is a list of basic provisions which should be carefully worked out and inserted in a partnership agreement. Accompanying them are brief comments either to indicate the importance of the provision, or advice as to its phrasing.

1. *Name and Purpose.*—The name should be chosen carefully, and will frequently bear the names of two or three partners (seldom more), or of the community. If the name of one or more partners is used to designate the professional firm, the contract should provide whether the right to continued use of such name is to survive the retirement or death of such partner.

2. *Location.*—The locality in which the partnership proposes to practice should be set out specifically. If the partners conclude that they wish to insert into the contract a covenant limiting the right of a withdrawing partner to engage in practice within a particular area for a particular time, this should be done carefully in the body of the agreement. It is also necessary that the area limited and the time provided in such case be reasonable under all the circumstances.

3. *Duties of Partners.*—The agreement should set out with care whether the partners are to give full or part time to the affairs of the partnership, and to provide any limitations on possibly conflicting

other professional activities, or on non-professional activities.

4. *Managing Partner.*—It is frequently advisable to designate a managing partner. This centralizes authority for purchasing, for making financial decisions, and for establishing essential supervision over nursing, technical and clerical staffs. It may be desirable to rotate the management so as to give all partners such experience over a period of time.

5. *Initial Valuation of Partnership Assets.*—It is important that the agreement designate carefully just what assets are included in the initial capitalization of the partnership. Such tangible assets as professional library, equipment, and cars, are relatively easy to evaluate. Such intangible assets as outstanding accounts and notes receivable are likewise fairly easy to evaluate. The difficulty arises when one seeks to place a monetary valuation on such intangible assets as an established professional name, the right to continue the use of that name, the value of an established practice, the value of an advantageous long-term lease, and the like.

6. *Capital Investment.*—The agreement should set out carefully the percentage of interest of each partner and the amount of capital to be paid by him; also which interests have been paid for, or partially so. Any partnership interest not wholly paid for should be the subject of carefully worked out business arrangements. The most common of these is the giving of a note without interest, or at a low rate, to be paid the lending partner or partners by the borrowing partner out of the latter's annual share of net partnership profits.

7. *Sharing and Definition of Expenses.*—While it might seem too obvious to insert, it has been found good practice for the contract to make it clear that all partners agree that expenses shall have the first claim on partnership gross earnings, also what items are to constitute such expenses.

8. *Sharing of Profits or Losses.*—The share of each partner in the net profits and losses of the firm should also be set out with care. This may, but need not be the same percentage as the interest of each partner in the capital structure. A younger physician, for example, might have the same financial investment in a medical partnership as an older partner, but be less productive of professional income. Ordinarily, the younger partner would not have the same drawing power. Such differences can be reflected by agreement as to the extent of participation of each partner in the net profits or losses of the firm. As a matter of law, the sharing of profits or losses is perhaps the most fundamental single test in determining whether a given association is a partnership or something else.

9. *Partnership Drawings.*—The actual financial outcome of a partnership year obviously cannot be determined until the year has ended and the books have been closed. The usual practice is to establish drawings for each partner which resemble salaries, but which are *not* deductible for income tax purposes as salaries are. The reason for the difference in treatment is that salary is an expense, but it is recognizable only where an employer–employee relationship exists. Partners are considered in tax law as associated self-employed persons who are not allowed to deduct as expenses what they earn and pay themselves. It is a prudent practice to establish aggregate drawings at not over 85 to 90 per cent of estimated net income. This allows the partnership to maintain a desirable working capital and to establish some savings for year end distribution or for periods when one or more partners is ill.

10. *Distributed vs. Distributable Shares.*—The problem in this field may be best illustrated by example. Assume that the share of Doctor X in the net cash income of a medical partnership for a particular year was $20,000. Assume during that year he had drawn $1,500 a month, or a total of $18,000. The latter figure of $18,000 is the *distributed* share, namely, what he actually got. The figure of $20,000 was his *distributive* share, or the one to which he was entitled on a bookkeeping distribution of the net earnings when the books for the year were closed.

Doctor X can draw or retain in the firm the $2,000 as soon as it has been determined that he is entitled to that extra amount as the balance of his share of profits for the year. He must, in any event, report that higher figure for *both* federal and state income tax purposes, whether he draws it out of the firm or leaves it there.

Conversely, if Doctor Y of the same firm drew $1,000 a month during the year, or a total of $12,000, and his *distributive* or earned share was found at the end of the year to be only $10,000, he would owe the firm the sum of $2,000. This is the excess of the *distributed* or estimated advance payment to him over what was ultimately determined to be his true or *distributive* share. He would report for income tax purposes not the $12,000 which he drew through erroneous estimate, but the $10,000 to which he was entitled by the terms of the partnership contract.

This point should be covered in the agreement.

11. *Vacation and Postgraduate Study.*—It is advisable to establish by formula the period of vacation of each partner. It is common to do this on a basis of the length of time a partner has been a member of a particular firm, or a predecessor firm in the same community. Agreed vacations are known to vary from a minimum of two weeks to as much as three months in this state.

In like manner, it may be advisable to provide by contract for the allowance of time needed for postgraduate studies, or for participation in affairs of professional medical organizations, should it be anticipated that one or more partners will desire or require a substantial amount of time for such purposes.

12. *Illness of Partner.*—On this important subject, four points may be emphasized. The first is that a medical partnership is generally collecting past due accounts. Thus, the financial impact caused by the sustained illness of a partner is not felt at once. Second, there is a difference between partial

and total incapacity. Third, there is a great difference between temporary and permanent disability, whether partial or total. It is well for a partnership agreement to provide the financial arrangements which are to control during the illness of a partner. Any such arrangements should take any of the three above factors into account.

A fourth factor is the amount of disability or time loss insurance which the partnership may carry for each of its members, or which the members may carry as items of personal expense. The premiums of such policies are not deductible for income tax purposes; neither are payments to physicians under such policies includable in gross income.

Following are typical arrangements made to cover the illness of a physician partner:

(*a*) If the illness or incapacity is partial, and does not extend beyond six months, no reduction is made in drawings.

(*b*) If such partial incapacity continues beyond six months, an adjustment in such partner's financial participation in the firm is to be negotiated which will recognize the extent to which he can practice his profession.

(*c*) If the illness or incapacity is total, maintain established drawings of such partner in full up to six month maximum.

(*d*) If such total incapacity continues beyond six months, reduce such financial participation by degrees, so that after 18 months, for example, the remaining partners could dissolve the firm, or make other arrangements suitable to them. Established drawings of such a partner might also be reduced after six months by the amount of his payments under disability or time loss insurance, up to an agreed figure or percentage.

13. *Withdrawal, Retirement, or Death of a Partner.*—Of all the problems faced by a partnership, there are probably none which are more difficult to evaluate and to solve by contract than the related problems of withdrawal, retirement, or death. As used in this connection, "withdrawal" means the optional leaving of a partnership, irrespective of cause other than health. "Retirement" is limited to the leaving of a partnership on grounds of health.

On consideration, it would seem rather evident that where a partner is withdrawing from a firm because the other partners wish it or because he desires to practice elsewhere, there are elements of dealing at arm's length and of individual judgment and volition which are lacking in the other two situations. Further, there is a far greater element of individual judgment and of negotiation possible upon retirement for health reasons than there is with an estate or heirs following death.

Some medical partnerships are beginning to reflect some of the above factors in the financial settlements made where a partner leaves a firm. Ordinarily, the settlement will be smallest where a partner *withdraws;* it will be more generous where a partner *retires* for reasons of health; it will be most generous where a partner *dies* without having withdrawn or retired. The legal and tax considerations of such arrangements call for careful draftsmanship if the wishes of a partner and the maximum advantages of such arrangements are to be assured.

14. *Insurance.*—The partnership agreement should consider at least two types of insurance. The first is what insurance is to be carried by individual partners. This would ordinarily include individual malpractice and car insurance.The minimum limits of such policies should be set out in the agreement, or left in the discretion of the managing partner. It may also include minimum amounts of disability or time loss insurance.

The second type of insurance is that to be carried by the partnership, generally as an expense. This would include public liability on the premises of the partnership; partnership malpractice insurance covering the potential liability of all partners for the professional acts of any one of them; workmen's compensation and employer's liability; fire and extended coverage on equipment and library of the partnership; rental or similar insurance to cover special expenses in connection with loss due to fire or other casualty, non-ownership automobile and hired car insurance; comprehensive coverage on the cash and securities of the partnership, including wrongful loss or mysterious disappearance.

If the partnership concludes to carry disability or time loss insurance on its partners, this can be handled by the partnership as a matter of convenience, but it should be charged to the individual drawing accounts of the partners, since such premiums are not deductible for income tax purposes. The same holds true for the same reason, among others, of life insurance, which is discussed in the next paragraph.

A third class of coverage, although not treated in the partnership agreement, is life insurance, which the partners carry on the lives of each other. Thus, if Doctors X, Y, and Z were partners, and each of them was insurable, it is a common practice to provide by a *separate* contract, wholly independent of the partnership agreement that Doctors Y and Z will insure the life of Doctor X and pay the premium thereof in agreed ratios, and that Doctors X and Z will do the same for Y, and Doctors X and Y will do the same for Doctor Z.

The above arrangement can also be handled through a trust agreement, although this is needlessly cumbersome and costly unless a large insurance program is involved. While premiums on such policies are not deductible as expense, the receipt of insurance proceeds by the surviving doctors is not taxable as income. Neither are such insurance proceeds taxable to the estate of the deceased doctor where he did not own or control the policy.

15. *Professional Records.*—It is well for a partnership agreement to provide what disposition is to be made of case histories and other professional records in the event of retirement, withdrawal or

death of a partner, or dissolution of the partnership.

16. *Dissolution.*—If an agreement is silent as to dissolution of a partnership, the Wisconsin statutes control. Where special arrangements are preferred by partners, it is believed desirable that this subject be spelled out in the partnership agreement.

### Conclusion

Few personal or professional decisions are more important in the life of a practicing physician than that of entering into a partnership. It is necessarily an intimate relation at professional, financial, and personal levels. It should not be entered into lightly, or with undue haste. Each partner should know the professional qualifications, the character, and the habits of the other. Personal congeniality is highly desirable because of the inevitable closeness of the working arrangement.

Once the above considerations have been duly weighed, the matter should be carefully discussed with an attorney. If the latter should not be familiar with certain of the ethical and other considerations which distinguish medical practice and which should carry over into medical partnerships, the physicians should inform their attorney on such points. It is also believed prudent, in terms of time saving and tax saving, to have partnership books established and periodically audited by a certified public accountant.

Partnerships which are entered into with the care above indicated and recommended should have a correspondingly greater likelihood of successful operation and survival.

# Physicians and Child Placement

THE Attorney General, in an opinion to the Wisconsin Department of Public Welfare, concluded that a physician who assists in, or arranges for, the placement of a child by its parent or guardian in the home of a stranger, violates the Wisconsin Statutes. Illustrative cases are set forth and considered in the Opinion, and indicate the extent to which a physician may properly act in this field. The Attorney General's opinion may be found at 37 O.A.G. 403.

### Illustrative Cases

"A. The physician who confined Miss A, an unmarried mother, learned that she had expressed a wish to place her child for adoption. He therefore informed Mr. and Mrs. Y, who were patients of his, that he knew of a child that would be available for adoption. He gave the name of the adoptive parents to the mother. They made arrangements to transfer the child to them upon discharge from the hospital. The adoptive parents sent a relative to meet the mother outside the hospital and the relative transported the child alone to the prospective adoptive home.

"B. The physician who confined Miss B, an unmarried mother, learned that she had expressed a desire to place her child for adoption. The physician told the mother that he knew a desirable adoptive home. He communicated with the proposed adoptive family, telling them about the child and suggesting that they employ an attorney. Subsequently the attorney visited the mother and obtained the mother's consent. Upon discharge from the hospital the mother and child were met by the adoptive parents who took the child to their home.

"C. A nurse employed on the staff of the hospital where Miss C was confined, learned that Miss C wanted to make an adoptive placement of her child. The nurse talked to Miss C and informed her that she knew a family who would be interested in adopting her child. She also informed the family about the child and suggested that they come to the hospital to see the baby and to talk with the mother.

"D. Miss D informed her physician that she wished to place her child for adoption. The physician informed her that he knew families who wished to adopt and offered to take the baby and place it in an adoptive home. Miss D consented to this and the physician took the baby to the adoptive home.

"E. Miss E informed her physician that she wished to place her child for adoption. The physician told Miss E that he knew of a good home for the child. Miss E stated that because of her confidence in the physician she would place the child with anyone he recommended. The physician then informed the prospective adoptive parents and suggested that they employ an attorney. They conferred with an attorney, informing him that they had received information from the physician about a child that was available for adoption. The attorney conferred with the mother and arranged through the physician's office to personally take the baby upon the mother's discharge from the hospital. Thereafter, the attorney personally took the baby from the mother and delivered it to the adoptive parents. The attorney justified his actions on the grounds that he deemed it a desirable service to his client to prevent the mother from learning the names of his clients and to prevent the clients from learning the name of the mother. It was the position of the attorney that the mother had made the placement and that he had nothing to do with the actual placement as distinguished from the adoptive proceedings. You inquire whether the attorney violates section 48.37 (1) in that he "assists" in the placement.

"In case A it is our opinion that on the narrow fact situation presented no successful prosecution could be maintained. While it could be argued that one who gives information gratuitously to the par-

ties performs a material act of 'assistance,' it is our view that unless more could be shown it would be impossible to obtain a conviction. If the physician, in addition to informing the prospective adoptive parents of the existence of the child, actively promoted the placement, there would be a clear violation. But just passing on the information is insufficient in our judgment to warrant a prosecution. The doctor could always say that nothing he did prevented the parties from using proper channels in obtaining the placement. Nor was the act of the relatives in taking possession of the child for the adoptive parents, after the arrangements had been made, sufficient in our judgment to warrant prosecution.

"In case B it is also our view that the physician should not be prosecuted for merely giving the information, particularly since he suggested employment of an attorney. The attorney, according to the facts stated, merely performed a legal service in obtaining the mother's consent and did not 'assist' in or 'arrange' for the placement in the sense meant by the statute.

"It should be repeated, however, that in both cases A and B if additional facts were shown there might well be grounds for prosecution.

"In case C it does not appear that any placement was made, but the nurse informed the mother that she knew of a family who would be interested in adopting the child, and also told the family about the child and suggested that they come to the hospital. Her conduct was not such as to violate section 48.45 (1) because it does not go so far as to constitute a representation that she was *able to dispose of* the child.

"Case D is a clear violation of section 48.37 (1) since the physician did everything necessary to the placing of the child.

"In case E the physician knew that his recommendation would be followed because of the mother's confidence in him. It seems that he did more here than in either case A or case B. It would appear that he *recommended* the prospective foster home. If so he 'assisted' the mother in placing the child by making such recommendation and by putting the parties in touch with each other, notwithstanding his suggestion that an attorney be employed. The attorney also clearly 'assisted' in and 'arranged' the placement. His attemped justification is not valid, since he did more than perform a legal service. His theory would result in exempting attorneys altogether from the application of sec. 48.37 (1). Such exemption was not put in the statute by the legislature and cannot be read into it by implication."

The Attorney General, in the same opinion, discusses the reasons why the state itself, or through its licensed private agencies, has undertaken to perform the function of child placement.

"Experience has shown that so-called 'irregular' placements do immeasurable harm in many respects. They have come to be known popularly as constituting a 'black market' in babies. Even the most well-intentioned persons usually lack the necessary training and are unable or unwilling to make the necessary investigation to determine whether a particular placement is in the best interests of the child. Sometimes, not always, pecuniary matters are permitted to outweigh considerations of the child's welfare, as when the prospective foster parents agree to pay the lying-in expenses. But even in cases where that element is lacking, a great deal of mischief may result. The prospective foster parents may find later that the child has physical or mental defects or conversely the foster home may not be suited for the child. It may happen, too, that proper legal steps to terminate the rights of the natural parent or parents or to obtain their consent to an adoption have not been taken and later on the natural parent or parents cannot be located, or even in some cases identified."

### Statutes on Child Placement

"**48.37 Licenses; Records; Reports.** (1) No person other than the parent or legal guardian, and no firm, association or corporation, and no private institution shall place, assist, or arrange for the placement of any child in the control and care of any person, with or without contract or agreement, or place such child for adoption, other than a licensed Child Welfare Agency.

"**48.40 Violations.** (1) Whenever the State Department of Public Welfare shall be advised or shall have reason to believe that any person, firm, corporation, association or private institution, is conducting or acting as a Child Welfare Agency in this state without being licensed as in this chapter provided, or is in any way, directly or indirectly, offering to place any child or holding himself or itself out as being able to place or dispose of children in any manner, it shall make an investigation to ascertain the facts. If it finds that such person, firm, corporation, association or private institution is so acting without a license, it either may issue a license upon application therefor, or may cause a prosecution to be instituted under the provisions of Section 48.41.

"**48.41 Penalties.** (1) Any person who shall act as a Child Welfare Agency without a license as provided in this chapter or who shall violate any of the provisions of the Statutes relating to the organization, conduct and operations of Child Welfare agencies, or who in any way, directly or indirectly, offers to place or dispose of any child or hold himself out as being able to place or dispose of children in any manner whatsoever, shall upon conviction thereof be punished by a fine of not less than ten nor more than five hundred dollars or by imprisonment in the County Jail for not more than one year, and said term of imprisonment in case of an association or a corporation may be imposed upon its officers who participated in said violation."

If questions arise regarding particular cases, it is suggested that the physician contact the Division of Child Welfare at 315 South Carroll Street, Madison, Wisconsin.

# Who's Who in Health in Wisconsin

## A Directory of Voluntary and Governmental Agencies in the Field of Public Health

### AMERICAN CANCER SOCIETY, WISCONSIN DIVISION

ROY B. LARSEN, M. D.

**President:** Roy B. Larsen, M. D.

**Executive Director:** Robert O. McLean

Address: 652 E. Gorham St., Madison 3, Wisconsin

Phone: 5-8879

This voluntary organization directs its activities into two major channels—to physicians and to the general public. For physicians, the Society offers postgraduate courses and films, journals, monographs, and slides on a loan basis. For the public, the Society engages in research into the causes and relief of cancer, education for the prevention of cancer, and service to individuals suffering with cancer. Dressings are available in every county for home or hospitalized patients. Physicians are urged to contact county cancer units for dressings or loan closet materials. Traveling postgraduate cancer clinics are held each year for physicians. In addition, there are annual cancer institutes for nurses, dentists and teachers. Speakers and exhibits are provided for professional meetings of all types.

### AMERICAN RED CROSS

**Director, Badger Regional Blood Center:** Merle O. Hamel, M. D.

**Administrative Director:** L. J. Petersen

Address: 302 East Washington Avenue, Madison, Wisconsin

Phone: 5-0021

M. O. HAMEL, M. D.

Blood and some of its by-products are distributed to 58 civilian hospitals in counties comprising the territories of 34 Red Cross Chapters participating in the Badger Regional Blood program; gamma globulin from blood collected by the Red Cross is distributed by the State Board of Health to doctors throughout the entire state upon request to the State Board of Health. This organization also distributes serum albumin directly to doctors in limited quantities and upon request. Northwest Wisconsin is served by the St. Paul Regional Blood Program. County chapters provide instruction in home care of the sick, first aid and water safety, recruitment of nurses to be assigned to polio treatment centers and instruction in the health aspects of food and nutrition.

### DEPARTMENT OF PUBLIC INSTRUCTION

G. E. WATSON

**State Superintendent:** George E. Watson

Address: 147 North, State Capitol, Madison, Wisconsin

Phone: 6-4411, Ext. 589

Through supervision of elementary and secondary schools of Wisconsin this department is concerned with the health of school people. A special supervisor in health and physical education conducts health activities among school students and personnel. A building services division is concerned about health and sanitation aspects of school buildings under the department's supervisory jurisdiction. In the Bureau of Handicapped Children several programs are carried out which involve medical services. Each year about 200,000 children obtain audiometric tests. Hearing difficulties discovered in these tests are referred to otologic clinics in which county medical societies participate. Aid is provided crippled children and those with rheumatic fever. Programs are provided for the deaf and the hard of hearing. Physicians are requested to contact the Bureau whenever they have questions or referrals to make concerning children who might qualify for assistance.

### DEPARTMENT OF PUBLIC WELFARE

**Director:** John W. Tramburg (on leave)

**Acting Director:** George M. Keith

Address: State Capitol, Madison, Wisconsin

Phone: 6-4411, Ext. 681

J. W. TRAMBURG

This department is responsible for more than $30,000,000 in state property and annual expenditure of $60,000,000 of federal, state and local funds. It administers laws concerning the charitable, curative, correctional and penal institutions and services, and laws concerning old age assistance, aid to dependent children, aid to the blind, and relief. It supervises medical and therapeutic treatment of patients in the hospitals for mental diseases, colonies for the mentally deficient, and the county hospitals for the mentally ill. It operates the bureau of alcohol studies, program for adult blind, and student loan fund for needy college students. It provides medical and health services to many aged, juvenile, needy, and physically handicapped persons through private practitioners.

## DEPARTMENT OF VETERANS AFFAIRS

G. A. HUSEBY

**Director:** Gordon A. Huseby

Address: Rm. 12A, South, State Capitol, Madison, Wisconsin

Phone: 6–4411, Ext. 311

This department renders health, educational, and economic assistance to veterans of the armed forces of World War II and the Korean conflict and their dependents. Medical or hospital care is contingent upon the temporary emergency aid and there being evidence of want or distress. Misconduct or lack of compliance with the law precludes favorable consideration. Prior authorization is a prerequisite for other than emergencies in which event notice must be filed with the department within five days. Applications should be initiated through the county veterans service officer of the county in which the veteran resides.

## INDUSTRIAL COMMISSION

**Chairman:** Voyta Wrabetz

**Secretary:** Miss Helen E. Gill

Address: 1 West Wilson St., Madison, Wisconsin

Phone: 6–4411, Ext. 786

VOYTA WRABETZ

The commission administers workmen's compensation laws and regulations pertaining to safety and sanitation. The compensation act provides for payment of compensation and for all necessary medical treatment to injured employees of employers subject to the act. The State Medical Society's "Open Panel" program is part of the administration of the workmen's compensation act.

## MARQUETTE UNIVERSITY SCHOOL OF DENTISTRY

O. M. DRESEN, D.D.S.

**Dean:** O. M. Dresen, D.D.S.

**Secretary:** R. G. Haukohl

Address: 604 N. Sixteenth Street, Milwaukee 3, Wisconsin

Phone: Division 4–1000

This is the only center of dental education in Wisconsin. A maximum of 115 freshmen dental students and 42 dental hygiene students are accepted in the fall of each year. Dental students are required to have a minimum of two years of pre-dental liberal arts college before admission to the dental school, and receive four years of training in the dental school.

## MARQUETTE UNIVERSITY SCHOOL OF MEDICINE

J. H. HIRSCHBOECK, M. D.

**Dean:** John S. Hirschboeck, M. D.

Address: 561 No. 15th St., Milwaukee, Wisconsin

Phone: Division 4–1000, Ext. 341

Marquette University School of Medicine conducts an educational program for the undergraduate training of men and women for the practice of medicine. It also conducts postgraduate courses for physicians, supervises the training of physicians for the medical specialities, and conducts an educational training program in physical therapy, leading to either a B. Sc. in physiotherapy or a certificate in therapy. The school operates the Variety Club Heart Center, a diagnostic unit for special study in heart diseases; the Milwaukee Cancer Diagnostic Clinic, and the Marquette Eye Clinic.

## NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

**Southern Wisconsin Representative:** Francis Strapp

Address: 119 E. Washington Avenue, Madison, Wisconsin

Phone: 5–5824

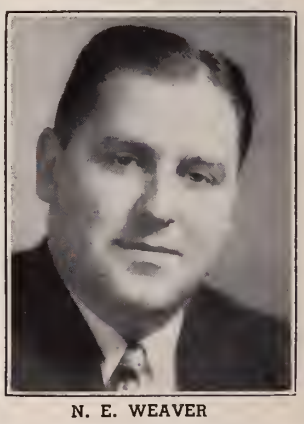
**Northern Wisconsin Representative:** Norman E. Weaver

Address: 508 First Street, Wausau, Wisconsin

Phone: 8–9166

The Foundation offers (1) a patient care program in which polio patients receive direct financial aid as needed for the payment of hospital and medical bills, procurement of appliances, transportation to medical centers, etc.; (2) epidemic services which provide emergency equipment such as respirators, hot pack machines, rock-

FRANCIS STRAPP



N. E. WEAVER

ing beds, and aid in obtaining and financing emergency personnel; (3) professional education including a program of scholarships, fellowships, and grants to increase the number of technicians and medical specialists needed for polio care and treatment. The Foundation recently began a program of polio prevention providing gamma globulin and a vaccine validity study. Patient care aid is obtained directly from county chapters of the Foundation.

## OFFICE OF CIVIL DEFENSE

**Director:** Major General Ralph J. Olson

**Co-director for Health Services:** Carl N. Neupert, M. D.

Address: 25 East, State Capitol, Madison 2, Wisconsin

Phone: 6-4411, Ext. 424

MAJ. GEN. R. J. OLSON

The office of Civil Defense is building 102 medical teams in the state mobile support program; stock-piling medical supplies for these teams; arranging for blood to be procured for their use; arranging with hospitals to expand their facilities to accommodate casualties, van ambulances to transport casualties from first-aid stations to hospitals; and outpatient care of casualties. State and county medical societies have supplied the pattern which is being followed in building these medical teams. The state office is training the radiologic monitors for the teams and is assisting in training such specialists in political subdivisions. A technical manual for medical teams to use in their operations is being distributed.

## STATE BOARD OF DENTAL EXAMINERS

BYRON ISING, D. D. S.

**President:** Byron Ising, D. D. S.

Address: Oshkosh

The board is composed of five members appointed by the governor for five-year terms. It is the duty of the board to conduct examinations for license to practice dentistry and dental hygiene, to admit dentists from other states after examining their qualifications, and to revoke licenses for cause. The board must decide that dentists desiring to practice in Wisconsin are ethical and capable of providing high quality dental care.

## STATE BOARD OF EXAMINERS IN THE BASIC SCIENCES

**Secretary:** W. H. Barber

Address: 621 Ransom Street, Ripon, Wisconsin

Phone: Black 564

W. H. BARBER

The board grants certificates of proficiency in the basic sciences (anatomy, physiology, pathology, and physical diagnosis) on the basis of examination, reciprocity, or waiver. Examinations are held four times each year at such times and places as the board may choose. Candidates are required to present evidence of graduation from an accredited high school or its equivalent and two affidavits as to good moral character. The State Board of Medical Examiners, the State Board of Examiners in Chiropractic, and the State Board of Dental Examiners are required by law not to admit to their examinations or license or register any applicant unless such applicant first presents a certificate of registration in the basic sciences.

## STATE BOARD OF HEALTH

S. E. GAVIN, M. D.

**President:** Stephen E. Gavin, M. D.

**State Health Officer:** Carl N. Neupert, M. D.

Address: Rm. 400, State Office Bldg., Madison 2, Wisconsin

Phone: 6-4411, Ext. 511

The State Board of Health has general supervision of the health and life of citizens throughout the state. This department directs activities involving vital statistics, laboratories, dental and health education, hospital construction, cosmetology, barbering, funeral directing and embalming, communicable diseases, tuberculosis, venereal disease, cancer and heart disease control, sanitary engineering, plumbing, well drilling, rendering and slaughtering, water pollution control, maternal and child health, school health nutrition, child guidance centers, local health administration, public health nursing, industrial hygiene, and hotels and restaurants. The Board is vested with prescribed powers of regulation and enforcement in matters pertaining to public health. The Board determines policies for the administration of the department and adopts rules and regulations pertaining to its statutory functions. Eight district health offices assist local boards of health and health officers in all towns, villages, and cities of the state in supplementing the work of the department. Also under its supervision is the State Laboratory of Hygiene in Madison. The Board publishes a Biennial Report, Health (a quarterly bulletin), special publications and pamphlets on a wide variety of health topics, and a catalogue of health films.

## STATE BOARD OF MEDICAL EXAMINERS

**President:** J. W. Prentice, M. D.

**Secretary:** Thos. W. Tormey, Jr., M. D.

Address: 1140 State Office Building, Madison, Wisconsin

Phone: 6-4411 Ext. 400

J. W. PRENTICE, M. D.

The Board was created in 1897. It licenses applicants to practice medicine and surgery, osteopathy, and chiropody. 1953 legislation created registration in physical therapy and provided for the granting of temporary educational permits. The Board has the duty of enforcing the regulations of the Medical Practice Act. Members of the Board are appointed for terms of four years.

## STATE BOARD OF PHARMACY

**President:** J. P. Lee

**Secretary:** Sylvester H. Dretzka

Address: 794 North Jefferson Street, Milwaukee, Wis.

Phone: Broadway 6-0394

J. P. LEE

The board examines applicants for registration as pharmacists and after hearing may suspend or revoke licenses for cause. In addition its duties are the enforcement of the basic pharmacy law and the laws on narcotics and poisons. Drug stores are licensed and checked for registered personnel; prescription rooms, equipment, and sanitation are also checked. The board issues permits for the operation of drug stores, drug manufacturers and pharmacies in hospitals, and inspects the same.

## STATE BOARD OF VOCATIONAL AND ADULT EDUCATION

C. L. GREIBER

**President:** R. L. Pierce

**Executive Officer and State Director:** C. L. Greiber

Address: 316 State Office Building, Madison, Wisconsin

Phone: 6-4411, Ext. 758

The board, through its rehabilitation division, provides a variety of services to handicapped citizens of Wisconsin. The program of vocational rehabilitation seeks to meet the needs of handicapped citizens through counseling, training, and medical services which will assist in improving their economic status. Training may be provided through a university, college, or on the job.

## STATE DEPARTMENT OF NURSES

**Board President:** Ruth Coe, R. N.

**Board Secretary:** Adele G. Stahl, R. N.

Address: 119 Monona Avenue, Madison, Wisconsin

Phone: 6-4411, Ext. 335

RUTH COE, R. N.

This department licenses and re-registers graduate nurses and trained practical nurses—establishes minimum standards for schools of nurses and trained practical nurses; places qualified schools on the accredited list; initiates rules, regulations, and policies to improve nursing education; and administers a scholarship fund for graduate registered nurses of Wisconsin.

## UNIVERSITY HOSPITALS

**Superintendent:** H. M. Coon, M. D.

Address: 1300 University Avenue, Madison 6, Wisconsin

Phone: 6-6811

H. M. COON, M. D.

The University Hospitals include the Student Infirmary, the Mary Cornelia Bradley Memorial Hospital, the State of Wisconsin General Hospital, the Wisconsin Orthopedic Hospital for Children, and the Cancer Research Hospital. This grouping makes up 900 hospital beds. The University Hospitals are the teaching hospitals of the University of Wisconsin Medical School. The hospitals also provide human services for certain persons who would be unable otherwise to secure such care.

## UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

W. S. MIDDLETON, M. D.

**Dean:** W. S. Middleton, M. D.

**Executive Secretary:** H. M. Coon, M. D.

Address: 418 North Randall Avenue, Madison 6, Wisconsin

Phone: 5-3311, Ext. 2554

Its primary function is the training of physicians and ancillary services to medicine; i.e., nurses, medical and x-ray technicians, occupational and physical therapists. Graduate training in preclinical sciences and for the clinical specialists is afforded. Postgraduate opportunities for practicing physicians are coordinated with the State Medical Society of Wisconsin, and members of the faculty are available for professional meetings throughout the state.

## UNIVERSITY OF WISCONSIN SCHOOL OF PHARMACY

**Dean:** A. H. Uhl

Address: 355 Chemistry Bldg., University of Wisconsin, Madison, Wisconsin

Phone: 5-3311, Ext. 2517

A. H. UHL

The major function of the school is to train students in pharmacy, offer postgraduate work to practicing pharmacists, and prepare teachers and research workers. It also conducts research in pharmaceutical science and provides extension services for pharmacists and physicians in the state.

## VETERANS ADMINISTRATION REGIONAL OFFICE, MEDICAL DIVISION

**Chief Medical Officer:** S. E. Sebastian, M. D.

**Medical Administrative Officer:** Wallace W. MacDonald

Address: 342 North Water Street, Milwaukee 2, Wisconsin

Phone: Broadway 2-6085

S. E. SEBASTIAN, M. D.

Outpatient treatment, medical or dental, including necessary medicines, prosthetic appliances, and other supplies is provided veterans of the military or naval services, who are eligible under laws administered by the Veterans Administration. Home-town medical care is provided through contract with the Wisconsin Veterans Medical Service Agency of the State Medical Society.

## WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION

REV. A. F. BERENS

**President:** Rev. A. F. Berens, S. J.

**Executive Secretary:** C. W. Kammeier

Address: 1018 N. Jefferson St., Milwaukee 2, Wisconsin

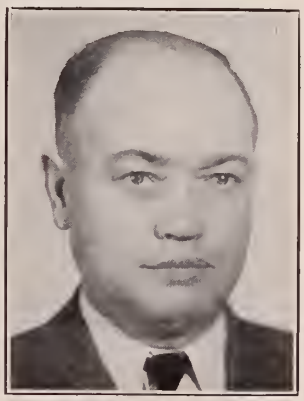
Phone: Broadway 6-5487

This association conducts case finding through tuberculin testing programs, mobile x-ray clinics, and consultation on referred cases; medical social service, including help to patients and families in resolving social, emotional and economic difficulties pertaining to medical recommendations, plans for sanatorium admission regardless of legal residence; rehabilitation; education and research.

## WISCONSIN ASSOCIATION OF THE DEAF, STATE SERVICE BUREAU

**Director:** R. W. Horgen

Address: 312 Woodland Circle, Madison 4, Wisconsin



R. W. HORGEN

The Service Bureau carries on publicity for better understanding of the deaf people and their employment, civic and personal problems; promotes the economic and educational well-being and safeguards the interests of the deaf; serves as an intermediary for deaf individuals or groups in their dealings with various local and state agencies.

## WISCONSIN ASSOCIATION FOR THE DISABLED

**President, Board of Directors:** Clare D. Rejahl

**Executive Secretary:** Kenneth L. Svee

Address: 119 East Washington Avenue, Madison 3, Wisconsin

Phone: 5-2789

K. L. SVEE

This association provides services for disabled children or adults which are not available through any other sources. Major projects are Camp Wawbeek, a recreational camp for the disabled; Wisconsin Homecrafters Shop, an outlet for the sale of articles made by the homebound; two cerebral palsy evaluation and treatment centers; and a public education service. Through affiliated county units, assistance in medical care, special education, prosthetic equipment, and transportation are provided.

## WISCONSIN ASSOCIATION FOR MENTAL HEALTH

WALTER W. ARGOW

**President:** Mrs. L. C. Senescall, Sheboygan

**Executive Director:** Walter W. Argow

Address: 119 East Washington Avenue, Madison, Wisconsin

Phone: 5-8746

The Wisconsin Association for Mental Health, founded in 1935, is a citizens' voluntary organization to create better public understanding of the nature and problems of mental health and emotional illness through public information and education, demonstrations and special service projects on prevention and patient care, field consultation and organization service, securing funds for research, and conducting related social studies.

## WISCONSIN ASSOCIATION FOR PUBLIC HEALTH

**President:** E. R. Krumbiegel, M. D.

**Secretary-Treasurer:** Paul Weis

Address: 1 West Wilson Street, Madison, Wisconsin

Phone: 6-4411, Ext. 511

E. R. KRUMBIEGEL, M. D.

This organization sponsors an annual state convention which presents national authorities in public health and provides an opportunity for Wisconsin professional public health workers to meet each other and work together in small sectional groups.

## WISCONSIN COUNCIL OF SAFETY

**President:** E. Clark Woodward

**Exec. Secretary-Treasurer:** R. W. Gillette

Address: Rm. 234, State Office Building, Madison 2, Wisconsin

Phone: 6-4411, Ext. 451

E. CLARK WOODWARD

This Council organizes two statewide conferences and three technical clinics each year. Programs include subjects on industrial and public health. It gives advice and assistance to (1) regional groups who organize six regional conferences annually on health and safety, (2) local groups carrying out like programs in 27 active safety councils found in major cities. It publishes a quarterly bulletin, *Wisconsin Safety News*, with circulation of 6,000 copies. It conducts a statewide contest among industrial groups with 25 awards given out. It cooperates with the University of Wisconsin in developing and promoting safety and health training courses and provides a list of qualified safety and health speakers.

## WISCONSIN WELFARE COUNCIL

MRS. DONALD SHEPARD

**President:** Mrs. Donald Shepard

**Executive Secretary:** Morris Hursh

Address: 440 Washington Bldg., Madison, Wisconsin

Phone: 5-2663

This Council is a voluntary social-planning organization, organized in 1881, to encourage the development of better health and welfare services through the promotion and support of needed state legislation. It sponsors institutes and workshops on a district and state level for the discussion of health problems.

## WISCONSIN PHARMACEUTICAL ASSOCIATION

**President:** Kent Lundgren

**Executive Secretary:** Jennings Murphy

Address: 161 W. Wisconsin Ave., Milwaukee 3, Wisconsin

Phone: Broadway 1-4384

KENT LUNDGREN

A grievance committee has been created to serve the physicians and the public by eliminating illegal and unethical conditions in the practice of pharmacy, when such are found to exist. A professional activities committee has the function of promoting the best possible professional services to the physician and to the public. A public health committee exists to serve the physicians and the local medical societies and county health organizations in their programs of education about cancer, diabetes, heart, tuberculosis, etc.

## WISCONSIN STATE SCHOOL HEALTH COUNCIL

**Chairman:** L. O. Tetzlaff

**Executive Secretary:** Frank O. Stangel

Address: 1111 N. 10th St., Milwaukee, Wisconsin

Phone: Broadway 1-4341, Ext. 348

L. O. TETZLAFF

The Council serves as a continuing policy forming and recommending body for the Wisconsin Cooperative School Health Program which helps the school, home, and community in promoting and preserving the health of each child.

## WISCONSIN CONFERENCE OF CATHOLIC HOSPITALS

MSGR. E. J. GOEBEL

**Advisor to Wisconsin Conference; Director of Archdiocesan Group:** Monsignor Edmund J. Goebel, Ph. D.

**Executive Secretary:** Miss Gertrude M. Gloeckler

Address: 437 West Galena Street, Milwaukee 12, Wisconsin

Phone: Concord 4-0930

This organization coordinates activities of the 56 Catholic hospitals in Wisconsin; serves as a clearing house for medical-moral problems; and establishes criteria for education and in-service training of the nursing and administrative personnel.

## WISCONSIN DIABETES ASSOCIATION

**President:** Maurice Hardgrove, M. D.

**Secretary-Treasurer:** Karl H. Beck, M. D.

Address: 642 North Fifth Street, Milwaukee 3, Wisconsin

Phone: Spring 4-0602

MAURICE HARDGROVE, M. D.

It arranges for yearly diabetes week during which there is a concerted effort to have everyone consult his doctor for a urinalysis; education for the physician through scientific literature, speakers and exhibits; education of diabetics for better control of their condition; and promotion of research in diabetes.

## WISCONSIN STATE NURSES ASSOCIATION

**President:** Mrs. Clara Brauer, R. N.

**Executive Secretary:** Mrs. C. D. Partridge, R. N.

Address: 161 West Wisconsin Avenue, Milwaukee 3, Wisconsin

Phone: Broadway 2-3670

MRS. CLARA BRAUER, R. N.

The organization maintains a center of information for potential recruits to student nursing, and for the general public. To help make nurses better informed in their profession, it conducts institutes for private duty, general and industrial nurses, publishes a *Bulletin* issued four times yearly, and a news letter sent several times a year. Through an economic security program, it helps insure job satisfaction for nurses.

## WISCONSIN COUNCIL FOR MENTALLY RETARDED CHILDREN

ROBERT S. McCORMACK

**President:** Robert S. McCormack

**Secretary:** Mrs. Fred Gee

Address: 2718 N. Prospect Avenue, Milwaukee, Wisconsin

Phone: Woodruff 4-0135

This is a voluntary organization to secure appropriations from the legislature for the Southern and Northern Colonies and for other state supported classes for mentally retarded children; to provide them with adequate personnel; to obtain for Wisconsin's mentally retarded children and their parents and guardians all of the rights to which they are entitled; and to assist in the education of the general public as to the causes, care, and needs of mentally retarded children.

## WISCONSIN HOSPITAL ASSOCIATION

**President:** Rev. A. H. Schmeuszer

**Executive Secretary:** N. E. Hanshus

Address: 310 Chestnut Street, Eau Claire, Wisconsin

Phone: 2-6611

REV. A. H. SCHMEUSZER

This is a voluntary association to promote the welfare of the public through the development of hospital and outpatient service. It encourages professional education, scientific research activities, and the health education of the public and cooperates with other organizations having similar objectives.

## WISCONSIN PUBLIC HEALTH COUNCIL

**President:** Miss Edith Bangham

Address: 704 E. Gorham Street, Madison, Wisconsin

Phone: 6-3101

MISS EDITH BANGHAM

The Wisconsin Public Health Council is organized to further public health in Wisconsin, and to promote the establishment of full-time health departments in local communities. The Council is vitally concerned with the development of community health councils which are organized to stimulate interest in programs for improvement of public health locally.

## WISCONSIN HEART ASSOCIATION

H. H. SHAPIRO, M. D.

**President:** H. H. Shapiro, M. D.

**Executive Director:** Grant Larned

Address: 642 North Fifth Street, Milwaukee 3, Wisconsin

Phone: Broadway 1-8716

It conducts a three-phase program consisting of research into the causes and cures of heart disease, education of the medical profession and the lay public, and community service. Research is being carried out through national channels and includes Marquette and Wisconsin universities. The results of research are brought to the medical profession by means of four periodicals distributed by the Heart Associations, as well as by cardiology courses and seminars. On a state wide basis there are mobile rheumatic fever clinics which are held anywhere in the state at the request of the county medical societies.

## WISCONSIN STATE DENTAL SOCIETY

H. F. HAHN, D. D. S.

**President:** H. F. Hahn, D. D. S.

**Executive Secretary:** Kenneth F. Crane

Address: Suite 412, 704 W. Wisconsin Ave., Milwaukee 3, Wisconsin

Phone: Broadway 6-5710

This society encourages the improvement of the health of the public and promotes the art and science of dentistry. To this end it actively sponsors dental health programs and exhibits for lay education, and promotes public health measures. Continuing professional education programs covering the latest advances in dentistry are also an important activity.

# Dispensing of Drugs by Physicians and their Employees

QUESTIONS regarding the legal implications of dispensing of drugs by physicians or their employees have arisen from time to time. The opinion of the attorney general of the State of Wisconsin, set forth below in its entirety, discusses in clear and simple language the physician's possible legal liabilities, generally, as well as the extent of his and his employee's authority to dispense drugs.

"*Physicians and Surgeons—Pharmacy:* Dispensing of drugs by physician to patient in course of professional treatment is exempt from provisions of ch. 151, the pharmacy law, and no violation of sec. 151.04 (2) or 151.07 (3) Stats., is involved where the particular prescription is delivered to the patient by the office girl who has been directed by the physician to select certain tablets from a designated container and package the same under the general supervision of the physician."

January 29, 1952

Mr. Sylvester H. Dretzka, Secretary
State Board of Pharmacy

"You have asked for our opinion as to the latitude which a physician may grant his office girl in the dispensing of drugs and for purposes of illustration the following factual situation is presented:

> 'The doctor has a stock of drugs on hand. After naming a patient, he orally or in writing instructs his office girl to furnish the patient with certain drugs. The girl selects a container from among several (For example—10 or more varieties of Sulfa tablets), and counts out the number indicated. She then packages and labels the package. The exchange is also completed by her with the patient. This girl, without professional training, prepares the entire transaction which would normally be prepared by a pharmacist as required.'

"We are asked whether this constitutes a violation of secs. 151.04 (2) or 151.07 (3).

"Sec. 151.04 (2) provides:

> '(2) No person shall sell, give away, barter, compound or dispense drugs, medicines or poisons, except paris green, in packages labeled "paris green, poison," nor permit it, in a town, village or city of five hundred or more inhabitants, unless he be a registered pharmacist, nor institute nor conduct a place therefor without a registered pharmacist in charge, except that a registered assistant pharmacist may do so under the personal supervision of a registered pharmacist, and may have charge during the pharmacist's necessary absence, not to exceed ten days. If the inhabitants are less than five hundred, only a registered assistant pharmacist is required.'

"So far as material here an exception to the foregoing provision is contained in sec. 151.04 (3) reading:

> '(3) This shall not interfere with the dispensing of drugs, medicines or other articles by physicians, * * *'

"Sec. 151.07 (3) provides:

> '(3) No person, except a registered pharmacist or a practitioner shall prepare, compound, dispense or prepare for delivery for a patient any dangerous drug.'

"In *State v. Maas*, 246 Wis. 159, 16 N.W. 2d 406, which involved the sale of drugs in a drug store by a clerk who was neither a registered pharmacist nor a registered assistant pharmacist, the court said at p. 165:

> 'The drug business is intimately associated with public health. The legislature has prescribed rules and regulations to protect the public from the mistakes of the untrained. Although the statute may be confusing, and very likely can be made to carry the meaning more clearly by a redrafting, its purpose appears to be the prevention of any but registered pharmacists or assistant registered pharmacists under the personal supervision of registered pharmacists, from selling or compounding drugs.'

"The court in that case had no occasion to consider the statutory exception in favor of physicians quoted above, and of course, this language should be read in the light of the factual situation as presented to the court. Nevertheless the case is significant as enunciating the principle that the drug business is intimately associated with the public health and that the purpose of ch. 151 is to protect the public from the mistakes of the untrained.

"See also *Hoar v. Rasmussen*, 229 Wis. 509, 514, 282 N. W. 652, where the court said:

> 'The circumstances of a pharmacist's or druggist's calling demand the exercise of a high degree of care and skill, such care and skill as an ordinarily prudent person would exercise under those circumstances, the highest degree of care and prudence consistent with the reasonable conduct of the business. The effect of a mistake may be swift and disastrous. There are many cases in which druggists have been held liable for injuries resulting from negligence in filling a prescription or supplying a remedy. * * *' (Citing cases.)

"This same principle of solicitude for the public health in the handling of drugs has been enunciated

many times by the courts. See, for instance, *Marigny v. Dejoie* (La. 1937), 172 So. 808, holding that all persons dealing with poisons, especially druggists, are bound to use the highest degree of care known among practical men to prevent injury from use of poisons.

"The hazard to the public health arising through the sale of drugs by an untrained person is equally great whether there is an absence of personal supervision by a licensed pharmacist or a physician.

"In 3 O.A.G. 555 it was considered that a practicing physician is not authorized to run a drug store without complying with the pharmacy law. In other words the exemption in favor of the physician applies exclusively to the furnishing of drugs prescribed by practicing physicians in the treatment of their own patients and they are not authorized to sell drugs to the general public indiscriminately. It is true that at the time the above opinion was written one exemption read: 'Nothing herein shall interfere with any practicing physician when dispensing his own medicines, or supplying his patient with such articles as may seem to him proper.' However, in 16 O.A.G. 722, after the exemption has been changed to its present form the same view was expressed as in 3 O.A.G. 555 with the observation, 'Since said opinion the wording of the pharmacy law has been somewhat changed on this subject, but for all practical purposes the meaning and the significance is the same.' P. 724.

"It is common knowledge that a physician who furnishes medicines to his own patients does not thereby conduct a 'drug store.' *Medico-Dental Bldg. Co. of Los Angeles v. Horton and Converse* (1942 Dist. Ct. of Appeal, 2nd Dist. Div. 3, Cal.), 124 Pac. 2d 56. Sec. 4031 of the California Code relating to pharmacy reads:

> 'This chapter does not apply to or interfere with anyone, who holds a physician's and surgeon's certificate and who is duly registered as such by the Board of Medical Examiners or the Board of Osteopathic Examiners of this State, with supplying his own patients with such remedies as he may desire if he acts as their physician and is employed by them as such and if he does not keep a pharmacy, open shop or drug store, advertised or otherwise, for the retailing of medicines or poisons.'

"There the exemption is more clearly spelled out than it is in Wisconsin, but there is no reason for believing that the legislative intent is particularly different as has been shown above in the administrative construction given our statute.

"So far as responsibility for the negligent acts of their employees are concerned the pharmacist and the physician stand on pretty much the same footing.

> 'In accordance with the elementary principle that the master who undertakes to perform a service is liable for the negligence of his servant who, in the scope of his employment, is performing the service undertaken, it is well settled that when a person has been injured through the negligence of a druggist's clerk, the druggist is liable.' 17 Am. Jur. 'Drugs and Druggists' Sec. 35.

"See also 28 C.J.S. 'Druggists' p. 517, chap. 9 (c).

"Also it is the established rule that a physician must exercise due care in selecting his assistants, and on the simplest principles of the law, agency, or of master and servant, a physician may be liable for the neglect or fault of his employee or servant. 41 Am. Jur. 'Physicians and Surgeons' Sec. 112.

"Following the theory that the exemption in ch. 151 in favor of the physician was intended to apply exclusively to the furnishing of drugs prescribed by a physician in the treatment of his own patient, or possibly the occasional furnishing of drugs to another physician, it would seem that any carelessness in delegating any part of the dispensing to his subordinate where harm resulted to the public might entail liability on the part of the physician or helper or both. But it nevertheless appears that it was not the purpose of ch. 151 to subject the physician or his helper to the jurisdiction of the board of examiners in pharmacy or to make such individuals criminally liable for the illegal dispensing or sale of drugs incidental to the treatment of a patient.

"However, where the relationship of physician and patient does not exist and a member of the general public applies either to the physician or his helper for the purchase of drugs without a prescription the exemption does not apply, since as above pointed out the exemption was not intended for the purpose of placing the physician in the drug store business but merely to help him to supply drugs to his own patient as an incident to their treatment. We understand, for instance, that certain complaints have been filed with the state medical grievance committee under sec. 147.195 wherein investigators have called at the offices of certain physicians and have been sold dangerous drugs such as phenobarbital by the office girl without any prescription whatsoever. In at least one case the sale was said to have been made by the office girl when the doctor was away on an extended vacation. In instances of that sort it may well be concluded that the physician is virtually operating a drug store without meeting the requirements of sec. 151.02 (9) regulating operation of such stores.

"But where the relationship of physician and patient exists many things may be done by an unlicensed assistant pursuant to direction and supervision of the physician and we will certainly not attempt here to gaze into the crystal ball for the purpose of conjuring up all the hypothetical situations which may arise under such relationship along with the appropriate answers to the problems presented. However, to illustrate the extent of the dele-

gation of important and even dangerous tasks to subordinates mention might be made of the fact that nurses administer anaesthetics, make hypodermic injections and attend to medication of patients pursuant to the physician's directions, and it is immaterial whether the nurse is registered or not except that she may not hold herself out as a registered nurse unless she is registered under ch. 149. *See Nickley v. Eisenberg*, 206 Wis. 265, 239 N.W. 426; 9 O.A.G. 87; 30 O.A.G. 245.

"Moreover there is authority to the effect that where a hospital nurse neglected to read the label on a bottle and inadvertently supplied formalin instead of novocaine requested by the surgeon, the surgeon was not liable unless it could be shown that by exercising ordinary care he could or should have been able to prevent injurious effects. *Hallinan v. Prindle*, 17 Cal. App. 2d 656, 62 Pac. 2d 1075. In this case the surgeon was permitted to introduce evidence of the custom of surgeons to accept from the attending nurse instruments, medicine and drugs without personal examination thereof. It should be stated, however, that there was nothing in the evidence to show that the nurse in this case was the servant, employee or even the agent of the doctor, she being the employee of the hospital.

"In view of the foregoing it is concluded that where a doctor has a stock of drugs on hand, and in the course of treating a patient he instructs his office girl to furnish the patient with certain named tablets which she proceeds to obtain from the container and measure out for the patient, delivering the same to the patient, there is no violation of sec. 151.04 (2) or sec. 151.07 (3) although the doctor may be liable for his own negligence or the negligence of his employee in such case. In any event the physician may not, except by complying with sec. 151.02 (9) either directly or indirectly through his employee engage in what amounts to a drug store business by the dispensing and sale of drugs to the general public where the relationship of physician and patient does not exist between him and the purchaser."

VERNON W. THOMSON
*Attorney General*

## UNIVERSITY OF MINNESOTA SCHEDULES CONTINUATION COURSES

**February 1–5: "Child Psychiatry for General Physicians, Pediatricians, and Psychiatrists"**

Consisting principally of small group discussions of common problems rather than didactic lecture material, the course will be presented under the direction of Reynold A. Jensen, professor of psychiatry and pediatrics at Minnesota. The guest faculty will include Sherman Little, M. D., Buffalo (N. Y.) Children's Hospital; Mabel Ross, M. D., U. S. Public Health Service; and Henry H. Work, University of Louisville Medical School.

**February 10–11: "Cancer Detection for General Physicians"**

This two-day course is presented under the joint auspices of the University of Minnesota and the Minnesota Division of the American Cancer Society. Registrants will observe and participate in the diagnostic activities at the University's Cancer Detection Center and are invited to attend the dedication program of the medical school's new cancer research unit, the Lyon Laboratories.

**February 15–16: "Fundamental Advances in Internal Medicine for Internists"**

Basic concepts in the fields of infectious disease, gastroenterology, and hematology will be discussed. Cecil J. Watson, M. D., professor and head of the department of medicine, and other members of University of Minnesota Medical School will present the course with the assistance of Walter Lincoln Palmer, M. D., of the University of Chicago School of Medicine and David Shemin, M. D., of Columbia University College of Physicians and Surgeons.

**February 18–20: "Infertility Problem"**

This course is designed to meet the needs of physicians frequently consulted by infertile couples. Dr. Alan F. Guttmacher, Director of the Department of Obstetrics and Gynecology, Mount Sinai Hospital, New York City, will be the guest speaker.

Medical and gynecologic procedures in diagnosis and management of sterility problems will be stressed, and fertility control and genetic aspects of infertility will be considered. Also scheduled is a panel discussion on the subject of adoption procedures.

# Signing of Death Certificate If No Attending Physician

QUOTED below is an opinion of the attorney general of the State of Wisconsin which clarifies the position of the physician, coroner, and local registrar regarding death certificates in the case where no physician was in attendance. In effect it states that the person desiring to dispose of a body must employ a physician to investigate the cause of death so as to enable the physician to prepare a death certificate.

"*Vital Statistics—Death Certificate:* If there has been no inquest and the physician called for the purpose refuses to sign death certificate (for lack of sufficient information), person desiring to dispose of body has responsibility of procuring a proper death certificate in order to obtain a burial permit under sec. 69.44 (1), Stats., and cost of investigating cause of death is necessary part of burial expense. 29 O.A.G. 470 followed.

"Coroner is not authorized to sign death certificate under sec. 69.41, Stats., unless there has been an inquest. But if there has been an autopsy under sec. 366.121, the autopsy surgeon may sign the death certificate.

"Local registrar may not sign death certificate under sec. 69.40, Stats., merely because physician refuses to do so for lack of sufficient information. He may do so only if no physician can be obtained early enough."

December 7, 1951

Dr. Carl N. Neupert
State Health Officer
State Board of Health

"You have requested an opinion with reference to the preparation of death certificates in cases where no physician was in attendance prior to death and a physician called for the purpose refuses to make a death certificate. You ask three specific questions:

> '1. Who should be held responsible for filling out and signing the death certificate in cases where the physician refuses to sign and where the coroner has not held an inquest?'
>
> '2. Is the coroner authorized to sign a death certificate without having held an inquest?'
>
> '3. Is the local registrar authorized to sign a death certificate when a physician refuses to do so or where a coroner is not authorized to sign the death certificate?'

"The answer to your first question is that the person desiring to dispose of the body by burial or cremation is obliged to obtain a proper death certificate in order to obtain a burial permit under sec. 69.44 (1), Stats., which provides as follows:

> 'The body of any person whose death occurs in this state shall not be interred, deposited in a vault or tomb, cremated, or otherwise disposed of, until a permit for burial or removal is issued, and no burial or removal permit shall be issued until a complete and satisfactory certificate of the death has been filed as herein provided.'

"If a physician's services can be obtained the local registrar is without authority to sign the death certificate. The applicable statutes are secs. 69.39 and 69.40 which provide as follows:

> '69.39 In case of death without the attendance of a physician, or if the certificate of the attending physician cannot be obtained early enough for the purpose, any physician employed for the purpose shall upon the request of the local registrar or his deputy, make such certificate as is required of the attending physician.'
>
> '69.40 When a physician cannot be obtained early enough and *only in such case*, the local registrar is authorized to insert the facts relative to the cause of death, from the statements of relatives or other competent persons, and the permit for burial shall be issued upon such information.'

"As pointed out in the opinion in 29 O.A.G. 470, the local registrar has no authority to employ a physician to investigate the cause of death and the law contemplates that the person desiring to procure the disposition of the body must retain a physician to investigate the cause of death, performing an autopsy if necessary, and pay the physician's fee for that service. Such fee is a necessary part of the burial expense.

"The answer to your second question is that the coroner is not authorized to sign the death certificate unless an inquest has been held. Sec. 69.41, Stats., is the applicable statute and provides as follows:

> 'Any coroner *who holds an inquest* on the body of any deceased person required for a burial permit, shall state in his certificate the nature of the disease, or the manner of death, and if from external causes or violence whether "probably" accidental, suicidal or homicidal, as determined by the inquest; and shall furnish such information as may be required by the state registrar to classify the death.'

"The cases in which a coroner is authorized to hold an inquest are limited by sec. 366.01, Stats. However, even in such cases there may be situations where no inquest is held but nevertheless an autopsy may have been conducted as authorized by sec. 366.121, Stats. In that case the autopsy surgeon could properly make the death certificate, but the coroner could not since his statutory authority is limited to cases where an inquest has been held.

"The answer to your third question is that under sec. 69.40 the only case in which the local registrar

is authorized to sign the death certificate is "when a physician cannot be obtained early enough." Clearly the case is excluded when a physician can be obtained early enough but refuses to make a death certificate because of lack of information. In that case the person desiring to dispose of the body must arrange for the physician to make the necessary investigation of the cause of death and pay him for such investigation, as set forth in the answer to your first question."

VERNON W. THOMSON
*Attorney General*

## SOCIAL SECURITY BENEFITS FOR DOCTORS

The income earned by a physician from his own practice or a medical partnership of which he is a member does not entitle him to Social Security benefits.

Doctors and nurses who are employed by organizations organized for profit have been covered by Social Security all along. Doctors and nurses employed by nonprofit organizations may be covered provided the employer waives its statutory exemption and two thirds of its employees sign a statement asking to be covered.

Many doctors, although now self employed, are currently covered under Social Security because of active military service at any time after September 16, 1940, or because of prior practice in the capacity of an employee of another physician. Such physicians will continue to be covered for a period after 1950, roughly equal to twice the length of time spent in military service or as an employee. For example, a physician who spent three years in active military service will be currently covered until the end of 1956 even though both before and after such service he was self employed.

If a physician dies while currently covered, his widow, so long as she has minor children under 18 years of age in her care, will be entitled to monthly survivor's benefits. Inasmuch as wage credits of $160 per month are given for military service, as contrasted with a maximum for other employment of $300 per month, the amount of the monthly benefit to the widow will not be the $168 maximum. It will however be substantial.

The physician and his wife will be entitled to old-age benefits for the balance of their lives, if the physician reaches the age of 65 years while currently covered.

A person becomes permanently insured and covered after 10 years covered work earned at any time after the original Social Security law was passed.

The amount of benefits payable was raised about 12 per cent in 1952 to conform to the increased cost of living. This affects present as well as future beneficiaries.

## POSTMORTEM EXAMINATION

A great deal of confusion has always existed about whose consent is required to permit a physician to conduct a postmortem examination with impunity. Sometimes the next of kin was not immediately available, or there were several persons of the same degree of kinship. The physician who performed such an examination without proper written consent did so at considerable personal risk.

Now, under the law, consent for a physician to conduct a postmortem examination is sufficient when given by the person who assumes custody of the body for burial, providing he is the father, mother, husband, wife, child, guardian, or next of kin. If none of these are available, consent may be given by a friend or person charged by law with responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

# Donations and Bequests For Research

IN HIS capacity as a counselor, the physician is often called upon to advise patients who wish to make gifts, donations, or bequests for the purpose of furthering progress in the prevention, control, and treatment of disease. Many physicians themselves wish to contribute to worthy projects in the furtherance of their profession and the medical arts and sciences. With most, this desire is prompted by personal experience or acquaintance with a particular disease or infirmity. Often, their desire to give is accompanied by inadequate knowledge of the means by which their intentions can be carried out.

Almost all charitable, scientific, and educational organizations are empowered by their articles of incorporation or their constitution and by-laws to accept gifts, devises, and bequests of money and property, both real and personal, and to manage and administer such money and property in manners adapted to the proper promotion of the purposes of the donor and the organization. This article is accompanied by a tabulation of the major health and scientific organizations and by the conditions under which they are willing to accept donations or bequests of any kind.

Unless restrictions are placed on their use, donations or bequests made to such an organization will be used for the general furtherance of the objectives and purposes of the organization as outlined in its articles of incorporation.

Persons wishing to assure the use of their donations for specific purposes must describe their intentions in writing at the time the donation is made. It is advisable to communicate directly with the organization to which such a donation is contemplated. The average organization is empowered to accept funds earmarked for specific purposes so long as the purposes fall within the scope of its charter. The board of trustees or a research committee usually evaluates all special requests to determine whether the proposed donation can be used for the purposes intended. Most organizations are very helpful in advising the donor how his contribution may be tailored to the purposes of the organization while carrying out his wishes. Some will make available to contributors a list of approved research projects that await financing.

### Direct Donations

When a contribution is made as a gift during the lifetime of the donor, it is customary for the donor to transmit the gift with a letter to the governing body of the organization, such as the board of directors, indicating the manner in which the funds are to be used and such other terms and conditions as might be appropriate. When the contribution is a large one, it is well to discuss the proposal with officials of the organization in advance.

### Bequests

If the contribution is to be made by a bequest set forth in a will, it is necessary to specify the title of the organization, and the purpose for which the contribution is to be used. The terms of the bequest may specify that the fund be used for "Research," in which case the organization would determine the particular field of research for which the donation would be used. If the bequest is to be used for research in a specific field or in the causes and cures of a particular disease, the terms should so specify.

The terms of the bequest should also provide whether the entire principal of the bequest, only the income earned on the principal, or both, should be used for the purposes indicated. It is suggested that bequests take the following standard form:

> "I give and bequeath to _____(name)_____, a corporation created under the laws of the State of _____, and located in _____, the sum of ($_____) Dollars, to be used in the furtherance of its objects and purposes."

When the donor wishes to earmark the bequest for particular purposes, the final phrase of the above statement may be reworded to express the intent of the donor.

### Memorial Contributions

Every organization accepting contributions offers the opportunity to memorialize the name of the donor or any other designated person in perpetuity. For example, if the bequest is given as a "living memorial" to a certain individual, the terms of the will should specify the name of the fund, such as the "John Doe Fund for Medical Research."

Most organizations employ appropriate procedures for acknowledging contributions according to the wishes of the donor. Families or friends of the person being memorialized may be notified of the establishment of the fund. Donors desiring this type of service are requested to supply the names of those to be notified.

### Tax Exemption

Section 72.79 of the Wisconsin Statutes states in effect that all transfers of property (defined as both real and personal) to or for the use of any community chest fund, foundation or association *organized and operated exclusively for religious, charitable, scientific or education purposes* shall be exempt from a gift tax. Wisconsin statutes also provide that when other states provide for a similar tax exemption, reciprocity will be granted. It is well to point out, however, that the laws relating to taxation are subject to change at any time and the donor of any substantial gift should consult an attorney for the current law on tax exemptions.

| *Organization* | *Procedure for Making Donation or Bequest* |
|---|---|
| **American Cancer Society** 47 Beaver Street, New York 4, New York | *Donations* to the national organization are divided—60 per cent to the state of origin, 25 per cent to the national research program and 15 per cent for the operation of the national office. *Bequests* to either the National organization or any of its divisions will be divided 60% to the state of origin and 40% for research, unless specifically designated for some other purpose. |
| **Wisconsin Division, American Cancer Society** 652 East Gorham Street, Madison, Wisconsin | *Donations*—Same as above. *Bequests*, made to the Wisconsin Division, will be used 100 per cent for whatever purposes specified. |
| **American Dental Association** 222 East Superior Street, Chicago 11, Illinois | Accepts general and specific donations, particularly for the advancement of dental research. |
| **Wisconsin State Dental Society** 704 West Wisconsin Avenue, Milwaukee 3, Wisconsin | Accepts general and specific donations, particularly for dental research and dental health education programs for the public. |
| **American Diabetes Association** 11 West 42nd Street, New York 36, New York | A medical organization which accepts general or specific donations for professional education, patient information, public education and case finding, and research. Please contact Association before making earmarked contributions. |
| **American Hearing Society** 817 Fourteenth Street, N.W., Washington 5, D.C. | The objectives of this organization are prevention of deafness, conservation of hearing and rehabilitation of the hard of hearing. It accepts donations for research, education or direct services through local affiliates to be used for general or specific purposes consistent with the above named objectives. |
| **American Heart Association** 44 East 23rd Street, New York 10, New York | Donations and bequests welcome. They are divided 25 per cent to the American Heart Association, Inc. unless the donor specifies differently. Half of the 25 per cent share is earmarked for research, and the remainder for national education and development of state associations. The 75 per cent share is budgeted to research in Wisconsin in the field of diseases of the heart and blood vessels; medical and nursing education; public education in prevention; and community service to cardiac patients. |
| **Wisconsin Heart Association** 642 North Fifth Street, Milwaukee 3, Wisconsin | Same as the American Heart Association. |
| **American Medical Association** 535 North Dearborn Street, Chicago 10, Illinois | Will consider donations or bequests made to it for general or specific purposes including research. Acceptance by Board of Trustees depends on conditions incident to the bequest. |
| **State Medical Society of Wisconsin** 704 East Gorham Street, Madison, Wisconsin | Members or others who contemplate donations or bequests to the State Medical Society for general or specific purposes are requested to contact the Secretary. |
| **American Medical Education Foundation** 535 North Dearborn Street, Chicago 10, Illinois | Contributions or bequests made to this AMA–sponsored Foundation are entirely devoted to support of medical education. Any gift may be earmarked for any one of the 79 approved medical schools in the nation. |
| **American National Red Cross** 17 & "D" Street, N.W., Washington, D.C. | The corporation may receive gifts, bequests, devises, legacies, and donations for such purposes as are within the general scope of its corporate purposes and powers, and upon such acceptance shall expend and administer such contributions for the purposes specified. Unless the local chapter is specified as the beneficiary, funds derived from gifts made by will, trust, or similar instrument, go to the national organization. |
| **American Pharmaceutical Association** 2215 Constitution Avenue, Washington 7, D.C. | Accepts donations or bequests for general or specific use. Suggest query before making earmarked contribution. |
| **Wisconsin Pharmaceutical Association** 161 W. Wisconsin Avenue, Milwaukee 3, Wisconsin | Same as American Pharmaceutical Association. |

| *Organization* | *Procedure for Making Donation or Bequest* |
|---|---|
| **American Public Health Association** 1790 Broadway, New York 19, New York | Funds earmarked for specific research accepted if the proposal is within the program and objectives of the Association (the protection and promotion of public and personal health). Communications are welcome. |
| **American Social Hygiene Association** 1790 Broadway, New York 19, New York | Accepts any kind of donation or bequest, including those for such specific research in the field of venereal disease control as it is "in a position to carry out with competence." |
| **Arthritis and Rheumatism Foundation** 23 West 45th Street, New York 36, New York | Accepts donations and bequests for general or specific research in the rheumatic diseases; improvement of community treatment facilities, and other stated objectives for control of arthritis and rheumatism. Earmarked donations and bequests are acceptable if designated purposes are in line with Foundation policies and program. With earmarked donation, send explanatory letter. For bequest, use a standard statement. |
| **The Arthritis and Rheumatism Foundation** Wisconsin Chapter, 756 North Milwaukee Street, Milwaukee, Wisconsin | Accepts general or specific donations. Contact association before making earmarked contributions. |
| **Marquette University School of Dentistry** 604 North 16th Street, Milwaukee, Wisconsin | Accepts donations for dental education and research. If a specific type of research is requested under a bequest, the Dental School will reserve the right to decide whether the fund and the research under it is appropriate before accepting the fund. Donations are to be made to the "Marquette University School of Dentistry." |
| **Marquette University School of Medicine** 561 North Fifteenth Street, Milwaukee 3, Wisconsin | Accepts donations for medical education and research. Donations are to be made to the "Marquette University School of Medicine." |
| **National Association for Mental Health, Inc.** 1790 Broadway, New York 19, New York | Accepts any funds for its program to promote the cause of mental health. Any contribution earmarked for specific research is subject to the approval of the Professional Committee or the Scientific Research Committee of the National Association. |
| **Wisconsin Association for Mental Health** 119 East Washington Avenue, Madison, Wisconsin | Accepts funds for the promotion and conservation of mental health, including those earmarked for specific research and educational activities. All program activities subject to approval of Board of Directors which includes representation from all professions. |
| **National Epilepsy League, Inc.** 130 North Wells Street, Chicago 6, Illinois | Accepts contributions for specific research in the causes and treatment of epilepsy. Funds may be earmarked for educational and clinic use as well as for pure and applied research. Donations may be made to national organization or its affiliated state groups. Request use of standard statement on bequests. |
| **National Foundation for Infantile Paralysis** 120 Broadway, New York 5, New York | Supported by the annual March of Dimes each January. To provide for the Polio Prevention program (provision of gamma globulin, vaccine validity study) in 1954, one-third of the net amount received is to be forwarded to national headquarters; of the remainder, 50% is retained by the chapters for local patient aid or to supplement national emergency aid, and 50% goes to national headquarters for research, professional education, and emergency aid to chapters. If the donor wishes the entire donation to be used for research, the donation must be accompanied by a statement to that effect. Accepts any contributions or bequests. |
| **National Fund for Medical Education** 2 West 46th Street, New York 36, New York | Accepts contributions or bequests to be used in support of the nation's medical schools. Acts as distributing agency for all funds collected for aid to medical schools, including contributions to the American Medical Education Foundation. |

| *Organization* | *Procedure for Making Donation or Bequest* |
|---|---|
| **National Multiple Sclerosis Society** 270 Park Avenue, Suite 7G, New York 17, New York | Accepts any contributions or bequests for use in program of combating Multiple Sclerosis. *Earmarked Gifts* are used as indicated by the donor, providing the project meets with the approval of the Medical Advisory Board and the Board of Directors. *Unearmarked Gifts* are used for general program and divided with the local chapter on a 60–40 basis, 60 per cent for the chapter and 40 per cent for the National Society. Interested donors may write the Society for information concerning the current research program and the approved proposed projects. |
| National Academy of Sciences—National Research Council 2101 Constitution Avenue, Washington 25, D.C. | Private non-profit scientific organization for the encouragement and promotion of all fields of scientific research. Representation includes major scientific societies. Its Division of Medical Sciences is concerned broadly with advisory services on both fellowship and research programs in clinical and basic medical sciences, in cooperation with university and other medical laboratories. Address inquiries to Business Manager regarding acceptance and administration of donations or bequests for these purposes. |
| **National Safety Council** 425 North Michigan Avenue, Chicago 11, Illinois | Accepts donations or bequests for general use or specific research and program projects in harmony with objective of reducing deaths and injuries due to accidents. |
| **National Society for Crippled Children and Adults** 11 South LaSalle Street, Chicago, Illinois | Accepts donations or bequests for education, direct service, or research. Will use funds for these three purposes unless otherwise specified. Donor may specify that fund be used for specific purposes by the Wisconsin Association for the Disabled. |
| **Wisconsin Association for the Disabled** 119 East Washington Avenue, Madison 3, Wisconsin | Accepts donations for research, education, and direct services for crippled children and adults. Requests donor to contact Association when wishing to designate funds for a particular purpose. |
| **National Society for the Prevention of Blindness, Inc.** 1790 Broadway, New York 19, New York | Accepts funds or donations for specific research when requested. Unrestricted donations may be used for medical research, preventive services, and education of lay and professional persons. In making bequests, use of standard statement is requested. |
| **National Tuberculosis Association** 1790 Broadway, New York 19, New York | Accepts any donations or bequests, but prefers they be given for general research purposes. |
| **Wisconsin Anti-Tuberculosis Association** 1018 N. Jefferson Street, Milwaukee 2, Wisconsin | Accepts donations and bequests for general or specific use in furthering the purposes of the association in the fields of education and demonstration for the eradication of tuberculosis and the rehabilitation of tuberculous persons. |
| **Sister Elizabeth Kenny Foundation** 2400 Foshay Tower, Minneapolis 2, Minnesota | Accepts contributions or bequests to finance varied program in field of polio. Funds contributed finance clinical research; provide scholarships to trained registered nurses and physical therapists to become Kenny Therapists; provide the Kenny treatment at no charge to polio victims; finance treatment centers; conduct medical seminars; and provide public information relative to the Kenny concept and treatment of polio. |
| **Student Loan Fund of the State Medical Society** 704 East Gorham Street, Madison, Wisconsin | Accepts donations or bequests to assist worthy and deserving medical students in attaining their professional education. Funds will be used at the direction of the Board of Trustees. Address donations to the Board. |
| **United Cerebral Palsy Associations, Inc.** 50 West 57th Street, New York 19, New York | Accepts donations for general or specific use in the care, treatment, and rehabilitation of the cerebral palsied and for research in cerebral palsy. Local United Cerebral Palsy affiliates exist in many communities and accept donations under the same conditions. |

| *Organization* | *Procedure for Making Donation or Bequest* |
|---|---|
| University of Wisconsin Medical School<br>418 North Randall Street, Madison 6, Wisconsin | Accepts funds or donations for general or specific research. Assures exact stewardship for any research program in areas where it is qualified to serve. Bequests should be made in standard statement to "The Regents of the University of Wisconsin" or "The University of Wisconsin Medical School" and specify the terms under which the bequest should be used. |
| Wisconsin Alumni Research Foundation<br>P.O. Box 2059, Madison 1, Wisconsin | Donated funds are usually incorporated in the general investment portfolio of the Foundation. All grants for research are made through the University of Wisconsin Research Committee. Distribution of yearly grants is at the discretion of this committee except for earmarked funds which carry with them specific directives when allocated to the committee. Address donations to the Board of Trustees. |

## POSTGRADUATE COURSES SCHEDULED ON HEART AND LUNG DISEASE

To bring physicians up to date on recent advances in the diagnosis and treatment of heart and lung disease, two postgraduate courses have been scheduled during February and March by the Council on Postgraduate Medical Education of the American College of Chest Physicians, in cooperation with the respective state chapters of the College as well as the staffs and faculties of the local hospitals and medical schools.

From February 15 to 19, the Second Regional Postgraduate Course on Diseases of the Chest will be held in New Orleans, Louisiana. The Seventh Annual Postgraduate Course on Diseases of the Chest will be held at Philadelphia's Bellevue–Stratford Hotel from March 15 to 19. Tuition for each course is $75.

For further information, write to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

## UROLOGY AWARD

The American Urological Association offers an annual award of $1,000 (first prize of $500, second prize of $300, and third prize of $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than ten years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association to be held at the Waldorf–Astoria, New York City, May 31–June 3, 1954.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before February 1, 1954.

# The Physician's Will and Estate

EVERY physician owes the duty to his wife and family to plan the disposition of the estate which he has built up during his years of practice. It also includes certain transactions which take effect during his lifetime. Primarily such planning deals with problems regarding the disposition of his estate at the time of death.

The need and desirability of planning, including the execution of a proper will, is discussed in this article. Briefly such planning is necessary (1) to prevent the operation of the intestacy laws, (2) to eliminate guardianship over the property of minors, (3) to prevent substantial depletion of the estate by ignoring tax saving devices, (4) to provide expert investment and management of the estate after the physician's death, and (5) to take care of any specific bequests which a physician may wish to make. Each of these is discussed more fully in the paragraphs which follow. In addition, care must be exercised that sufficient liquid assets are available to the estate for administrative costs and death taxes so as to avoid forced sale of property.

Some physicians may feel that their estate is too small to bother about planning its disposition. Most physicians have a small bank account, a few bonds or securities, household furniture, an automobile, and life insurance policies. Such an estate probably amounts to several thousand dollars. Many also own an equity in a home. Many of the reasons set forth in this article pointing up the necessity of a will apply just as well to the small estate as to the larger one. Furthermore, in the small estate, every dollar counts in so far as the surviving widow and children are concerned and care should be taken that these few dollars do the most adequate job possible.

When the physician arrives at the attorney's office to discuss his estate planning and will drafting, he should be prepared to present to the attorney a complete itemization of all of the assets owned by himself and members of his family, indicating the ownership of each asset, their original cost, and approximate present value. In addition, his life insurance policies should be left with the attorney for his examination and recommendations regarding settlement options, qualification under the marital deduction, and possible changes in beneficiary designations. In this connection it might be wise to arrange for the attorney to discuss the life insurance policies with the physician's life insurance agent. While life insurance generally passes independently of the physician's will, it is nevertheless included in the assets which become available upon a physician's death and must be included in the physician's estate for death tax purposes.

## The Joint Tenancy Trap

Many individuals are under the mistaken notion that the placing of one's property in joint tenancy with one's wife is a substitute for a will. As has been so often said, joint tenancy is a substitute for a will in about the same sense as a size 34 suit will fit all men. It will fit some men but not others. In the first place, joint tenancy always makes imperative the execution of wills by both husband and wife. A joint tenancy always involves a gamble as to who dies first. In many cases husband and wife may die within a short time of each other. Therefore, in order to insure the distribution of the estate upon the death of the surviving joint tenant in accordance with the desires of the parties, wills for both husband and wife become necessary.

Probably the greatest danger of joint tenancy lies in its tax implications, both death tax and income tax. It is commonly thought that when a person dies holding property in joint tenancy that only one-half the value of such property is included in the estate for inheritance and estate tax computations. This happens to be true for Wisconsin inheritance tax purposes. It is not true, however, for federal tax purposes. The federal tax authorities have ruled that regardless of whether a valid gift was made during lifetime of a joint tenancy interest and regardless of whether a gift tax was paid, the entire value of the joint property will be included in the taxable estate of the person who furnished the money for the acquisition of the property. In most cases, this will mean the physician himself.

This problem arises, of course, only where the estate is subject to federal estate taxes, namely an estate in excess of $60,000. Those physicians whose estates are presently less than this amount are not, of course, faced with the problem. Certainly, however, most physicians can anticipate accumulating substantially more than this amount during their lifetime, and therefore should bear this in mind when acquiring property of any type.

Income taxwise, the penalties of joint tenancy can be even greater. Again the penalty is limited to federal income tax as distinguished from Wisconsin income tax. For federal income tax purposes the gain on property sold by a surviving joint tenant is measured by the difference between selling price and its *original cost*. Valuation of the property for estate purposes has no bearing whatsoever upon the profit or gain for income tax purposes. As a result of the inflation which has occurred during the past 10 years, most assets have at least doubled in value. Therefore the profit from the sale of assets acquired at the beginning of this 10 year period will be substantial and would subject the widow to needless federal income taxes.

Furthermore, even in the case of those physicians who are acquiring property at today's high prices, it is strongly recommended that the property be not acquired in joint tenancy, since the inflationary tendencies may continue in the future. At any rate no

advantage is gained by holding property in joint tenancy during deflationary times.

It is recommended that physicians hold their property either in their own name individually or in the name of their wife individually, or as tenants in common. The term "tenants in common" is distinguished from "joint tenants" in that property held as tenants in common passes by will or by operation of the intestacy laws, whereas joint property passes independently to the surviving joint tenant. In so far as the federal tax laws are concerned a tenant in common suffers no penalty.

In the case of those physicians who presently hold property in joint tenancy, it is urged that they give strong consideration to changing ownership of the property from themselves and their wives as joint tenants to themselves and their wives as tenants in common. This can be done without incurring additional gift tax liability.

### Prevention of Intestacy Law Operation

In the absence of a will, the intestacy laws will govern the distribution of a person's estate. In Wisconsin, this means:

1. *If widow and two or more children survive,* one-third of the real and personal property passes to the widow and the remaining two-thirds is divided equally among the children. Where the deceased person owned a homestead at the time of his death, the widow has the right to use it until her death or remarriage. This homestead right is in addition to the one-third share which the widow takes outright.

2. *If widow and one child survive,* the widow again has the right to use the homestead until her death or remarriage. In addition, the widow is entitled to take one-half instead of one-third of the personal property. In so far as real property is concerned her share remains at one-third. The surviving child takes therefore one-half of the personal property and two-thirds of the real property and the remainder interest in the homestead.

3. *If widow alone survives,* and no issue of any deceased children survive, the entire estate passes to the surviving wife.

4. *If children, but no widow, survive,* the entire estate passes in equal shares to surviving children and issue of deceased children.

Certainly in the case of a young physician, the distribution in accordance with the Wisconsin intestacy laws, placing ownership of at least one-half of the estate in his children, would work a definite financial hardship on his widow. It would seem that in most cases the bulk of a young physician's estate should be left to his widow so as to insure to her the greatest financial means and security during the years when she must take care not only of her own support but also that of her fatherless minor children. It is true that if property comes into a minor's possession that the income therefrom and the principal amount if needed can be used for the support of the minor child. As is pointed out, however, in this article under the heading "Elimination of Guardianship" the use of such funds is fraught with many complications, leading many observers to consider such use of minor's funds more theoretical than practical.

In this age of automobile and airplane travel, there is always the chance that husband and wife may be killed in a common disaster. In this case, the physician's estate should benefit his minor children. However, even in this situation guardianship should be avoided and in most cases a trust presents a more satisfactory and flexible solution to the problem. Again a will is necessary because such a trust cannot be created otherwise than by will. This is discussed more fully under the heading "Elimination of Guardianship."

In the case of physicians who no longer have minor children some situations might present themselves in which distribution in accordance with the intestacy laws would carry out the testator's intentions. In most cases, however, his wishes to provide first for his widow veto such a method of distribution. Furthermore, a physician who no longer has minor children is generally middle-aged or more and has accumulated more than an average estate. Such a physician will need a will, if for no other reason than to prevent death taxes from materially reducing his plans and intentions for his widow and adult children following his death. It is possible, through a properly drawn will, to sharply reduce taxes and at the same time carry out substantially the testator's desires and intentions regarding his wife and children and other objects of his planning.

A physician whose intent, in so far as the distribution of his estate is concerned, coincides with the intestacy law of descent is the exception rather than the rule. This is true of young, middle-aged, or old physicians.

### Elimination of Guardianship

Care should be taken to avoid the placing of property outright in the name of a minor. In some cases, it is highly desirable to grant ownership rights in property to minors. In those cases, however, serious consideration should be given to the trust device of ownership during the minority of the child.

In all cases where property descends to minors under the intestacy laws, it does so absolutely and in the name of the minor outright. Inasmuch as the law presumes the inability of minors to manage and protect their property, a guardian subject to court direction must be appointed. In effect, another estate proceeding is commenced in the county court. The widow may be appointed guardian of her own children, but she must provide a surety bond and pay the premium. Furthermore, an annual accounting must be made to the county court.

None of the principal amount of the minor's estate can be used by the widow or other guardian without first getting permission from the court. This means that every time the widow wishes to use a portion of the minor's estate, petitions and court

orders must be prepared and presented to the court, thus entailing the employment of an attorney.

Furthermore, no portion of one minor's estate can be used for the benefit of another minor child. There are situations, for example, serious and prolonged illness, where from the widow's standpoint this might be desirable. In fact, it would undoubtedly have been the wish of the deceased husband that the wife use her own judgment in apportioning and using the principal in accordance with the needs of the several children.

Power of the guardian to invest minors' funds is strictly limited to low income producing securities. In effect, the majority of the investment is limited to government securities. Not only is the interest rate low, but government securities are fixed in amount and cannot, therefore, keep pace with inflation.

In all cases where it is desirable to have property pass to minor children, it is strongly recommended that trusts be created by will. Properly drawn trusts can give to the trustee discretionary power to use both income and principal for the minor's welfare. In addition, a "sprinkler" trust can be created, vesting in the trustee power to apportion and use principal and income for the several children in accordance with their varying needs.

A trust can also be so drawn as to give the trustee power to invest in preferred and common stocks, thus providing greater income and greater capital gain possibilities.

A guardianship ceases when the minor attains the age of 21 years. Oftentimes it may be advisable to withhold payment until the child has reached a more mature age. This can be done only through the trust device.

### Tax Savings

If the physician's estate, including life insurance and the entire amount of joint property, exceeds $60,000, considerable death tax savings can be effected by proper planning, without substantially disturbing his desires and intentions regarding his wife and children and other objects of his bounty.

*Marital Deduction.* The Revenue Act of 1948 introduced the marital deduction concept into the field of estate planning. It applies only to the federal estate tax and has no bearing whatsoever upon Wisconsin inheritance tax. In effect it provides that a person may leave to his surviving spouse one-half of his property, including joint property and life insurance, tax free. The remaining one-half is considered the decedent's estate for federal estate tax purposes. From this one-half is subtracted the specific exemption of $60,000. The balance is subject to tax.

For example, a net estate of $120,000 will pay no estate tax if the marital deduction is utilized, since the first $60,000 is tax free under the marital deduction and the specific $60,000 exemption offsets entirely the $60,000 remainder of the estate. If the marital deduction is not used, the tax on the estate of $120,000 is $9,500.

If the net amount of the decedent's estate is $200,000, the difference in tax payable is $27,900.

The entire estate can be given to the widow. Only one-half is eligible, however, for qualification under the marital deduction.

The portion of an estate which passes to the wife under the marital deduction will, of course, be subjected to tax upon the death of the wife, assuming her estate amounts to more than $60,000. The question therefore presents itself whether it would not be wise to leave the entire estate in trust, giving the wife the income therefrom during her life and paying the principal to the children upon her death. However, assuming the marital deduction is used, the combined taxes on the two estates (husband's and wife's) are still substantially less than the tax would be if computed on the entire estate of the husband. The answer is therefore no.

This is so because tax rates become progessively higher as the size of the estate increases. If the estate can be split into two smaller portions (as is done when the marital deduction is used) two $60,000 exemptions are made available. Also the higher tax rates are avoided because the lower tax rates are used twice in computing the taxes on the combined estates.

Much of this saving, due to utilization of the lower tax rates, will be lost, however, upon the death of the wife in those cases where the wife has a substantial estate in her own right.

Because of tax savings possible in most cases through use of the marital deduction, common disaster provisions in wills are also discouraged.

Three methods may be used to take advantage of the marital deduction. They are (1) an outright bequest to the wife; (2) a trust, all the income of which is payable to the wife for life and the principal payable to her estate; and (3) a trust, the income of which is payable to the wife for life together with a right in the wife to appoint the principal as she may choose during her life or by her will.

Most property, including life insurance and joint property, can be used to qualify under the marital deduction.

In most estate plans, substantial savings can result through use of the marital deduction. Great care must be exercised by the drafter of the will that the technical requirements of the Internal Revenue Code are met when attempting to qualify property under the marital deduction. If life insurance is sought to be qualified under the martial deduction, the settlement options must be carefully worded.

*Saving the Second Tax.* If the entire estate of the husband is given to the wife, an estate tax will be payable on the entire amount so inherited at the time of her death. In effect, this means that as to the one-half portion of the husband's estate which did not qualify under the marital deduction two

estate taxes will be paid—one at the time of the husband's death and the other upon the wife's death.

It is therefore recommended that the husband strongly consider giving to his wife the marital deduction share of his estate, and placing the remaining one-half in a separate trust, the income of which can be paid either to the wife for her life or accumulated for, or distributed to, their children in the discretion of the trustee. In either event, the principal of such trust should be paid over to the children upon the death of the wife or on their attaining a certain age. In this way, a tax will be paid on this portion of the estate only in the husband's estate, none being due at the time of the wife's death, since she had no interest in this portion subject to tax.

This tax saving device applies to Wisconsin inheritance tax as well as federal estate tax.

It might be well to point out here another objection to holding property in joint tenancy. Since such property passes independent of will, it can never escape the second tax unless it be included in the property making up the marital deduction.

*Income Tax Savings By Creation of Second Trust for Children.* In those cases where the estate is sufficiently large so as to enable the wife to maintain herself adequately from the income and principal of the marital deduction share, substantial annual income tax savings can result by splitting the non-marital deduction one-half of the estate into separate trusts for each child. In this way the income from such trusts will not be taxed, at top income tax rates, to the widow, but will be taxed as several separate entities, each utilizing the lowest possible income tax rates.

In addition, where the children have independent incomes, savings can result by giving the trustee discretion as to whether the income shall be distributed to the children. This is accomplished by retaining in the trust that income which, if distributed to the child, would place him in a higher income tax bracket than would be paid by the trust if not distributed.

*Income Tax Savings by Electing Life Insurance Installment Option.* When planning disposition of your estate consideration should be given whether to have the life insurance proceeds paid to the beneficiary in installments over a period of time. Included in the installments paid by the insurance company is interest. The tax authorities have held that none of the installments, including the interest, are subject to income tax. Over a period of years the amount of interest received free from income tax will be substantial. If, on the other hand, the insurance proceeds are paid in a lump sum and then invested by the beneficiary, the income therefrom will annually be subject to income tax.

It should be very carefully considered, however, whether the receipt of tax free income is not overshadowed by the fact that the rate of return paid by insurance is probably less than can be earned by a competent trustee. Furthermore, insurance installments, being a fixed obligation, cannot rise in value as trust property can, should inflation continue.

*Gifts During Lifetime.* By making gifts of portions of your estate during your lifetime, it is possible to avoid paying any federal transfer tax. The transfer may be subject in part to a Wisconsin gift tax, but the savings in federal estate tax far outshadow the small Wisconsin tax.

In effect, the federal tax laws allow a husband to give away tax free a basic amount of $60,000 during his lifetime. *In addition,* he may annually give away $6,000 to *each donee* without federal gift tax liability. These amounts are conditioned upon either the gift being to the wife or the wife consenting to the gift. If either of these conditions are not met, the amounts are $30,000 and $3,000 respectively.

Problems may arise where the physician seeks to make gifts to his minor children. The obstacles are not insurmountable. It will suffice to point out in this discussion that should such gifts be contemplated, competent counsel should be sought.

It is in the field of making lifetime gifts that the greatest savings of transfer taxes can be accomplished. Each physician of some means should give serious thought to this possibility.

Not to be overlooked when considering the possibility of lifetime gifts is the possible income tax saving. Since ownership of the property made the subject of the gift is no longer in the physician, the income will no longer be taxed to him but to the recipient. Inasmuch as the recipient will probably be in a lower tax bracket than the physician making the gift, savings will result. Furthermore, if substantial gifts to children are contemplated, the income will be divided into separate tax entities, each being able to use the lowest rates as contrasted with the fact that the income would be taxed at the top tax bracket in the physician's return were it still his income.

### Specific Bequests

A will is necessary in every case in which the physician wishes to provide specifically for a person or institution other than his wife and children. For example, if the physician wishes to leave a gift to charity or to a faithful employee, such bequest can be made only by a provision in a will.

A word of caution should be given regarding gifts to charities. Care should be exercised that the exact legal name of the charity is used, and the use which the charity is to make of the bequest, if any special one is desired, should be carefully spelled out.

### Expert Investment and Management of Estate

In the absence of a will, or in a will which provides that all of the property is payable outright to the wife or children, the property undoubtedly will not be as well managed or invested as was the case during the physician's life. It is generally recognized that the average widow is not equipped by

training, experience, or temperament to be a shrewd investor or manager of property.

Where the amount of the estate is sizable, serious consideration should be given to placing the bulk of the estate in one or more trusts. Of course, the trustee should be carefully chosen so as to secure for the physician's wife and children expert management and investment. Many of the banks in the larger cities throughout the state have trust departments employing full time personnel, trained in and doing nothing but the management and investment of trust estates. The average physician would do well to discuss the matter, including costs, with his local or nearby trust company.

Estate planning is in essence an effort to make equitable and prudent disposition of whatever property a physician has been able to acquire. It is one of the most important pieces of planning that a physician or other person does. It calls for competent and sympathetic advisors. At the very least he will need an insurance counsellor and an attorney. If his affairs are large enough to warrant it, and in particular if he has to consider alternative courses of action, he will also need the assistance of a professional accountant, an investment counsellor and an experienced trust officer, all working as a team.

## IDENTIFICATION BY BLOOD TEST

Whenever relevant to the prosecution by the mother, or defense by the alleged father, in an illegitimacy action, the trial court may order the mother, child and alleged father to submit to one or more blood tests to determine whether the defendant can be excluded as the father of the child. The results of the test are admissible only to prove that the defendant is not the father; the results of a test which show only that the defendant might be the father are not admissible. Such tests are conducted by a physician or physicians, licensed to practice medicine and surgery, or by another duly qualified person or persons, not to exceed three, who are appointed by the court and paid by the county. Sec. 52.36, statutes.

Whenever relevant in a civil action to determine the parentage or identity of any child, person or corpse, the court may direct any person or persons involved to submit to one or more blood tests under restrictions and directions deemed proper by the court. Only where definite exclusion of the person involved in the controversy is established by the test are its results receivable in evidence. Sec. 325.23, statutes.

## W. M. A. TO MEET IN ROME NEXT YEAR

The World Medical Association will hold its 1954 meeting in Rome, September 26 to October 2. Since 1954 is a Holy Year, there will be heavy demands for transportation and hotel reservations. Any A.M.A. member who wishes to attend this meeting should write to the World Medical Association, 345 East 46th Street, New York 17, as soon as possible. The W.M.A. will secure transportation and hotel reservations and will help plan any side tours of Europe which the member desires. No charge is made to the physician for this service.

# Disability Evaluation

By CHESTER C. SCHNEIDER, M. D.
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DISABILITY evaluation is not an exact science resting on mathematical rules which will inevitably produce the same conclusion irrespective of who operates the formula. The conclusions reached vary with the evidence and the significance attached to it, the previous experience of the expert, and the condition and reaction of the patient. Given the same facts, even conscientious experts can disagree about their significance, so the disagreement between experts does not imply dishonesty or incompetence on their part.

Appraisal of injuries and their immediate and future disability producing potentials is a complicated and important subject. It requires extensive knowledge of all diagnostic procedures necessary to evaluate the exact nature of the injury and the probable consequences of natural healing and degenerative changes over the remaining life of the patient. The expert must study the problem with an open mind, determined to assemble all the facts necessary for the establishment of a correct diagnosis and a fair and complete comprehension of all relevant matters. Too often prejudicial factors resulting from biased attitudes, limited and unbalanced experience, preliminary prejudicial conferences with lawyers or adjusters, too zealous a desire to be helpful to the interests being served, and hostile or ingratiating patient attitudes consciously or unconsciously channel the conclusions which he reaches. This is particularly true where the objective findings are in contrast with the subjective complaints and frequently accounts for the wide disagreement between otherwise honest and sincere experts.

After accurately assembling all the necessary information required to establish a diagnosis and to form the basis for an opinion, the expert must prepare a report which is clear, concise, adequate for its intended purpose, unpadded with unnecessary and irrelevant data and narration, and completely understandable. The preparation of an entirely satisfactory report is an art which every physician should assiduously practice throughout his career. He must bear in mind that the report is his sole agent in these matters and, if it does not impress the reader as being neat, thorough, well prepared, and understandable, it will fall short of its objective. The physician should know what is to be said and say it as clearly and briefly as possible. He should also put enough punch into his opinion to reflect solidity of character, and he should rest his conclusions on facts, accurately established, clearly set forth, and logically evaluated.

Traumatic situations in general may be subdivided into four large groups:

1. Those with no objective evidence of injury and no underlying defects or disease of antecedent origin.
2. Those with no evidence of injury but with underlying defects or disease of long standing.
3. Those with evidence of injury and no associated antecedent defects or disease, and
4. Those with evidence of injury and also with associated long standing defects or disease.

Obviously each of these groups requires different analysis and leads to divergent conclusions.

In Wisconsin and other states, helpful basic tables have been prepared by the Industrial Commission to guide the physician in estimating disability; these should be studied. They set forth the value of amputations at all joints of the extremities, the relative loss of function due to complete and partial loss of motion at each of these joints in various positions, the value of partial and complete loss of sight and hearing, and the disability due to reduction of length of the lower extremities. Through the aid of these tables, even defective conditions not included can be appraised by computing their disabling effect in relation to the tabulated conditions. The disability may vary according to special features that produce functional loss. Pain, loss of sensation, weakness, mechanical disadvantages, and reduced endurance must be added to disability for limitation of motion.

Every physician is perplexed and frequently confused by the patient with many complaints unsupported by objective evidence of recent injury and no antecedent disease. These purely subjective situations cause conflict of expert opinion. The conscientious expert must support his conclusions by substantial findings, and consequently his position becomes untenable when he assumes the existence of pain and disability without objective defects to explain them. Cautious and well trained experts will not allow themselves to be misled by the patient whose symptoms will vanish after the litigation has terminated. In these cases a conservative and reasonable attitude is safest, and the expert will do well to confine himself to a statement of the complete absence of objective findings, if that is the case, and to an opinion as to the existence of the alleged dysfunction and pain under the existing circumstances. It must, of course, be conceded that pain and disability can exist without detectable physical findings, and the expert must be aware of these possibilities and qualify his statements accordingly.

Injuries which disturb the circulation of vital structures often lead to slowly evolving defects which cannot be detected for months or years after the accident. Disc injuries in the neck or lower back, damage to articular cartilages in various joints, damaged nutrition to small bones of the wrist, and many other similar conditions are almost impossible to detect in their early stages and require careful investigation to diagnose. Until the tell-tale signs and symptoms of late degeneration appear, the expert can only suspect the underlying situation and advise delay in the final disposition of the matter.

Many cases of alleged disability following accidents occur in individuals who show no evidence of traumatic structural defects but in whom more or less advanced pathologic conditions of long-standing can be found. These include architectural defects of developmental or congenital origin which can easily be rendered symptomatic by an accident, even though they had been completely silent prior to that time. Structural defects in the lower back are peculiarly prone to become symptomatic after sprain, and it is amazing and disconcerting to note how unresponsive to normal healing such injuries can be. Chronic arthritis is another condition which may smolder silently for years only to be rendered painful by some relatively minor injury. Symptoms which may have been present but disregarded by the patient for a long time suddenly assume striking importance and cause great annoyance after a compensable accident. Grating or grinding of the bones in the neck is a most common phenomenon in middle-aged and elderly people, rarely causing apprehension or inconvenience until some slight accident has occurred, and then the patient regards the same symptom as proof of a serious injury with permanently disabling potentialities. Many people forget, or have learned to disregard, the consequences of an old non-compensable injury until the same area is reinjured under compensable circumstances. Then all the effects of the ancient injury are suddenly attributed to the recent one. In such instances the expert must exercise great care to segregate the old from the new.

Traumatic aggravation of chronic smoldering disease most certainly can occur. Influences inadequate to injure normal tissues can affect defective ones. These reactions are usually persistent and do not respond to treatment. They must be recognized and appraised in accordance with the experience of similar cases.

Injuries of the back have long been known for their difficulty of determination and evaluation. "Railroad spine," "sacro-iliac sprain," and more recently "disc lesions" have successively plagued the medical profession. This is due to the great frequency of injuries to the spine, the complicated anatomy of this region, and the relative ease of misrepresentation of symptoms which they permit. Often they do not disclose themselves by definite, objective signs. Even the x-ray and other special diagnostic facilities cannot always reveal evidence of injury. Consequently appraisal of injuries of the spine requires not only the most conscientious and searching investigation of the patient, including many special diagnostic methods, but demands also careful observation of the patient himself and his reaction to many special tests. In one way or another every tissue under suspicion can be subjected to investigation, and the complex picture of actual injury recorded. If the findings are consistent and logical, the conclusions are definite and irrefutable, but if they are confused and inconsistent, they arouse suspicion and doubt.

Injuries of the spine have strikingly contrasting potentialities. A wrenched neck may merely stretch a muscle or ligament causing only temporary discomfort and no permanent residuals or, it may fracture an intervertebral disc and lead to interminable trouble. A "broken back," so-called, may be only a cracked appendage of one of the vertebrae, or it may be a crushed vertebral body with or without paralysis from injury of the spinal cord. A "low back strain" or sprain may be a minor muscle stretch, or it can be a ruptured intervertebral disc, with or without protrusion of disc material into the spinal canal. This latter condition can, and frequently does, lead to chronic changes in the disc, maladaptation of the vertebrae to each other, instability of the lower spine, chronic back ache, sciatic nerve irritation, and even partial paralysis. All of these conditions can be diagnosed by careful examination including the use of x-rays, spinal puncture, injection of oil or air into the subarachnoid space, and special physical and laboratory tests. If an injury actually has occurred, the expert by means of a competent examination will be able to find evidence of it. If he does not obtain conclusive evidence of an injury or if the findings are inconsistent, he is justified in presuming that no abnormality is present. Often the patient's unsupported allegations represent only a part of the picture of his insincerity and unreliability.

Another feature of the spine which often leads to confusion is the presence of structural defects of congenital or developmental origin, which closely simulate those caused by trauma. Thus, wedge-shaped vertebrae (Scheuermann's Disease, Calve's disease, hemivertebrae, etc.), unattached portions of vertebral bodies (limbus vertebrae, unattached transverse spinous processes, unattached articular processes, etc.), unfused interarticular portions of vertebrae (spondylolysis, etc.), and many other defects may either be the result of congenital or ancient acquired abnormality or recent trauma. The physician who wishes to qualify as an expert must be able to differentiate these conditions.

# Important Changes Increase Benefits Under Group Disability Insurance Program

ON AUGUST 15, 1953, the Group Disability Insurance Program sponsored by the Society and providing participating members with weekly benefits for disability due to sickness or accident and hospital expense coverage, completed its third year of operation. Since about 80 per cent of eligible physicians are enrolled in the plan, a report of its continuing success will be of interest to all Society members.

During the three years the insurance company has paid more than 700 claims totaling approximately $450,000, with the largest single claim in excess of $8,000. This usage of the insurance protection indicates the importance of the program as a realistic service of the Society to its members.

This contract was originally designed to the specifications of the Group Insurance Committee and represented the result of some two years of study and negotiation. At the time of its adoption the Provident Life and Accident Insurance Company agreed that in the event the program appeared to be working any inequities, the contract would be amended to serve the best interests of the insured doctors. Certain changes were recommended to the Interim Committee, and these were adopted as of August 15, 1953. The most important of such changes was concerned with the definition of *total disability* as respects the professional man, which is quite different from that applying to the corporation executive or the salaried employee.

We have found a few cases of genuine substantial disability on the part of insured members where, under a strict interpretation of the total disability clause, benefit payment could not be made. Working with the insurance company, we have developed something which, so far as we know, is entirely new in this field of professional group insurance. Effective August 15, 1953, our group program provides for *partial disability for sickness* for as long as six months, in addition to the partial disability provision for accident. There is only one difference. This partial disability applies only in those instances where benefit for total disability has been paid for at least 30 days. While this is an entirely new development, we believe that it is strictly worthwhile, and it enables the group insurance plan to do a better job.

Over the past years a number of our members have expressed the opinion that the weekly indemnity of $75 is not adequate, and the insurance carrier was asked to offer a supplementary disability income of $25, bringing the total to $100 weekly. The insurance company agreed to the plan on the following basis:

1. The additional benefit of $25 weekly could be offered only to members ages 34 through 59.
2. The additional weekly indemnity could be continued only through age 69 whereas the basic policy continues insurance (at $50 weekly) through age 74.
3. As the coverage would be on an optional basis so far as the member is concerned, the company felt that it too would have to reserve the option of acceptance or rejection unless at least 75% of those eligible for the additional coverage actually applied for it.

Because of many plans available through memberships in various societies, it was decided that only those members who do not carry more than $150 weekly indemnity under plans made available to them by reason of membership in professional organizations would be eligible for the additional coverage. This does not have any effect upon regular *individual* accident and health insurance or upon total and permanent disability coverage under life policies, and the $150 weekly indemnity is exclusive of all coverage offered by the State Medical Society of Wisconsin. This supplementary disability income provision has been elected by a substantial number of the participating members.

As has been previously reported in *The Wisconsin Medical Journal*, the Provident plan is the only group disability insurance program officially sponsored by the State Medical Society. During the past two years, the Wisconsin program has drawn national attention; and, in pioneering certain features of this form of income protection, it has served to increase materially the number of group insurance policies available to the medical profession through other state societies and the national specialist academies and colleges. These have been examined critically. So far as is known, the Wisconsin program continues to offer the most in income protection benefits per dollar of premium charged.

The success of the Society's plan is the direct result of the high rate of member participation in it. Since making this protection available under such favorable rates and conditions is a vital service of the Society to its members, every effort is made to secure the enrollment of new members and to maintain the interest of those already covered. The Society asks that new members study the insurance outline which is furnished to them. New members of the Society who are under age 32 may apply within one year and members over age 32 within six months, without consideration of present physical condition or past medical history.

It should be noted that in creating this plan to the Society's own specifications, the prime consideration was to satisfy the need for a *basic* coverage to assist the younger physician in establishing his personal insurance program by taking advantage of the Society's collective purchasing power, which makes possible broad coverage at minimum rates.

Claims have been paid promptly and equitably with only a limited number of situations in which the Society has been asked to intervene in matters of contract interpretation or where an inequity appeared to be working against either the claimant physician or the insurance company.

Inquiries regarding the coverage may be directed either to the Society or to Marsh & McLennan of Wisconsin, Inc., 825 North Jefferson Street, Milwaukee 2, Wisconsin.

# The Unlicensed Physician

March 27, 1952

A. G. Koehler, M. D., Secretary
Wisconsin State Board of Medical Examiners
46 Washington Boulevard
Oshkosh, Wisconsin

Dear Doctor Koehler:

A question is frequently put to me, and I am always puzzled as to how best to answer it. When Doctor Dawson was secretary of the State Board of Medical Examiners, I think he and I were in pretty fair agreement relative to it, and it has just occurred to me that I should tell you of the question and how I answer it so that if my views are not in accord with yours, we will have opportunity to reach some common agreement upon the point.

I have reference to the situation, not infrequently presented, where a physician comes to Wisconsin and associates in practice with others here in the state. His arrival is in the interim between examinations conducted by the State Board of Medical Examiners, and the question presented is what, if anything, he may do in the field of medical practice.

I advise very strongly against engaging in any activity which, in itself, constitutes medical practice. I advise these physicians that as unlicensed physicians in the state, their malpractice insurance may be void. They cannot sign vital statistics, they cannot appear in court, and they are not entitled to use any legal method for the collection of fees.

I suggest that all case records must be entered by the licensed physician or physicians in the office, that the unlicensed physician should not see patients and prescribe for them independently of consultation with those who are licensed. I advise that all prescriptions issued must be issued by licensed physicians and that the non-licensed physician should in all ways avoid any implication that he is actively engaged, on his own, and as a licensed physician, in the practice of medicine.

Frankly, I am afraid that I discourage this situation whenever possible as I feel that there are many legal implications involved and a physician, particularly one who has been engaged in practice over any period of time, may unwittingly, probably as a matter of habit, engage in activities which may subject him to criticism or actual difficulty.

Are you in general agreement with the reactions I express? I will be glad to hear from you.

Sincerely yours,
/s/ C. H. Crownhart
*Secretary*

April 1, 1952

Dear Mr. Crownhart:

Thank you for your letter of March 27, concerning my opinion relative to the practice of medicine by unlicensed physicians in Wisconsin between the time they arrive in the State of Wisconsin and the time they are examined by this Board for purpose of licensing them.

This continues to be a situation which presents itself repeatedly and which is still very much a problem of enforcement of both Wisconsin Statutes and Board policy.

While a physician may enter the State of Wisconsin as a locum tenens, an "apprentice," or a resident, with every intention of becoming licensed at the first Board meeting in the future, he is, although unintentionally in some cases, still practicing medicine illegally. It is almost impossible for a physician to be employed in one of these capacities without engaging in some activities which constitute the practice of medicine.

We are heartily in accord with your opinion on this subject, and the policy expressed by Doctor Dawson on behalf of the board at that time is still in effect.

Yours very truly,
Wisconsin State Board of Medical Examiners
/s/ A. G. Koehler, M. D.
*Secretary*

# Malpractice and the Physician*

By LOUIS J. REGAN, M. D., LL. B.

THE incidence of malpractice claims increased tenfold during the decade between 1930 and 1940. In some localities, malpractice claims have become so frequent that any patient with a less than perfect end result is a potential malpractice claimant. If this alarming situation were evidence that the medical profession was becoming increasingly inefficient, then the solution would of course be obvious. But the blunt truth is that the majority of all malpractice suits filed are without merit; more than half of them involve physicians who are above the median of their respective groups in skill, experience, and professional standing. The search for a solution to this problem demands an understanding of what actually constitutes malpractice, an analysis of the causes of malpractice claims, and a universal knowledge among physicians as to the positive steps which may be taken to decrease both the relatively few justified claims and the preponderantly greater number of unjustified claims.

## Any Physician May Be Sued for Malpractice

The bringing of a malpractice action does not even suggest that the claim has merit; for any patient may bring such an action against any physician who has attended him professionally. Nevertheless, the practitioner who is the target of the accusation is damaged by the mere filing of the action. Accordingly, it is necessary that every physician understand what constitutes malpractice under the law.

## What Constitutes Malpractice Under the Law?

The law requires that a physician who undertakes to diagnose or to treat a patient must possess the skill and exercise the care commonly possessed and exercised by other reputable physicians in the locality. If he holds himself out as a specialist, he must meet the standards of practice of the specialist in the designated field of practice. These legal interpretations of his duty are not changed if the professional services are rendered gratuitously. It follows, then, that no malpractice charge is justifiable unless the physician's service to the patient does not meet the requirements of good medical practice; unless in the diagnosis or treatment of his patient, the physician omits to do something he should do or does something he should not do in terms of accepted standards of practice. The standard of practice is always determined by what other reputable physicians in the community, or in similar communities, would or would not do in the care of similar cases.

This definition of standards needs further clarification; for medicine is not an exact science, and not all patients who are given medical treatment get well. Many are left with some disability or deformity. There are few conditions in which there is available a sole, specific, universally utilized remedy or procedure. There is frequently a great latitude for honest difference of opinion, and often the attending physician must exercise his best judgment in deciding which of the several methods to adopt. In certain circumstances, the physician's acts or omissions may be so unseemly and shocking as to be generally recognized as reprehensible and supportive of legal liability. On the other hand, complications or untoward and unexpected results are not uncommon, and the mere fact that a patient is not cured or does not progress favorably does not suggest culpable ignorance or negligence on the part of the medical attendant.

## Under Law, What Skill and Care Has the Patient the Right to Expect?

In the absence of evidence to the contrary, the law presumes that a physician has exercised the ordinary skill and care required of him in treating his patient. He is justified if his conduct of the case would be approved by even a respectable minority of his confreres in the same locality. He may make a mistake in diagnosis or be guilty of an error of judgment; he may use medicines or methods of treatment different from those which some of his colleagues would have used; he may obtain a bad result instead of a satisfactory one; but no one of these things is sufficient to fasten upon him the charge of malpractice. Actionable malpractice consists in doing something that should not be done or in omitting to do something that should be done.

## Malpractice Suits Lessen Public's Confidence in Medical Profession

It is of primary importance, of course, that every physician familiarize himself with his legal interpretation of what does and what does not constitute malpractice. But that is only the first part of the control of the malpractice contagion; for experience has taught us that the most meticulous attention to the dictates of good medical practice is not sufficient to ward off unjust claims and that no physician, regardless of his excellence, is immune. The misunderstanding, indeed the ill will, which has been engendered by the great number of unjust malpractice suits has tended to break down the public's confidence in the medical profession. This situation has important and far-reaching implications for both the public and the medical profession; for the public interest is adversely affected when the physician in

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caring for his patient is forced to give thought, time, and energy to safeguarding himself against the possibility of an unjust malpractice claim. The public should be informed of the facts of this problem, for in the long run, it is the public—in the persons of individual patients—whose well being is being jeopardized. There is no relationship outside the family which is so personal and intimate as that of physician and patient, no relationship in which the character, integrity, and conscience of one party are so important to the well being of the other. The overwhelming majority of physicians faithfully and unselfishly meet the demands and obligations of their calling; and the majority of patients do not unjustly file malpractice suits. The acts of the ignorant, the greedy, the callous few—among either patients or physicians—must not be permitted to destroy the merited esteem in which the profession as a whole is held.

### How Much Shall the Physician Tell His Patient?

As a basic step in improving the situation, the physician must realize that at all times he is obligated to act with the utmost good faith toward his patient. Thus, if he knows that he can not accomplish a cure or that the treatment adopted will probably be of no benefit, he is duty bound to advise his patient of these facts. It is extremely doubtful that a physician has a therapeutic privilege to withhold a specific diagnosis from a patient who is sick with serious or fatal illness. To the contrary, the confidential relationship requires in ordinary circumstances that the physician make a frank and full disclosure of all the pertinent facts to any adult and mentally competent patient. Such completely open handling of a case would do much to improve the physician-patient relationship and to remove the possibility of unjust malpractice actions. However, there are other unavoidable and even psychological factors in the practice of medicine which must also be considered carefully in this respect.

### Factors That Promote Malpractice Suits

If physicians were always able to obtain perfect results there would be, of course, no malpractice actions. But deaths, untoward and unexpected results, continuing disabilities, and complications occur and will continue to occur. Whether or not the uncured patient brings an action is often determined by his feeling toward the physician. Patients who have a feeling of friendly trust for the physician and who believe that everything possible has been done for them are not so likely to sue for malpractice—even when bad results ensue. Malpractice suits more often arise if the patient is resentful of some fancied or actual affront, if he believes that he has not been sufficiently closely attended, or—above all—if some third person raises a doubt in his mind as to the propriety of the treatment. In regard to this last point, it would be sheer folly to assume that the "third person" is always—or even most often—a layman who is uninformed about the facts of the case. Regrettably, many of these people are physicians who are also uninformed about the details and facts but who precipitate unjustifiable suits by criticising directly or by implication the work of physicians who have cared for particular cases.

Another potential danger to the physician-patient relationship arises from the physician's lack of attention to certain elements of patient psychology as factors in malpractice causation. Although the patient is sick or injured when he comes to his physician, he nevertheless visualizes himself as he was prior to becoming sick—with his body structures intact. Thus, unless the physician understands this viewpoint and prepares the patient properly, the patient with a fracture, for example, is likely to compare the final result with the part prior to injury, not with the injured member as presented to the physician. As another example of patient psychology, the average patient is not disposed to understand an error in diagnosis or the failure to make an early diagnosis. Or again, the unwarned patient is not happy with the surface tissue changes which are some times associated with deep x-ray therapy.

An analysis of malpractice claims reveals the significant fact that they arise almost invariably out of the first course of treatment. In other words, it is rare indeed that an old patient instigates a suit against his physician. It is obvious, then, that from the very first contact—indeed, especially with the very first contact—the physician should do everything within his power to develop an honest, frank, and psychologically sound relationship with his patient.

### How Physicians May Safeguard Themselves Against Malpractice Suits

The foregoing discussion has analyzed what malpractice is and what can be done in the physician's conduct to avoid real malpractice or to forestall the filing of an unjust claim. But it would be completely unrealistic to assume that any course of conduct on the part of the physician would prevent his being unjustly sued for malpractice. Good medical practice in itself is not enough; the physician must be able to defend his actions by proof of what he has done. He must not only know his legal duty to his patient, but he must fulfill it. He must know and take advantage of every measure to protect himself against the unjustified claim of malpractice. Under present circumstances, it is absolutely foolhardy for any physician to be ignorant of or careless of malpractice prophylaxis. He must take positive actions carefully based upon his legal responsibilities and liabilities.

To begin with, a physician is not legally obligated to undertake the care of any patient. But from the time he assumes the responsibility until he is discharged or withdraws from the case, he must give—or be sure that there is given—the care and treatment required by the condition of the patient. Before a physician may, without legal liability, with-

draw from a case he must give reasonable notice of his intention and allow the patient reasonable opportunity to fill his place.

By notice or special contract, the physician may limit the service he is to render. He may agree to treat the patient only at a certain place, or for a limited time, or for certain conditions. On the other hand, he may increase his obligation by expressly agreeing or warranting that he will effect a particular result; in this circumstance, he will be liable on his contract or warranty if he fails to fulfill the agreement. A physician is not an insurer of results unless he makes himself one by his special promise.

Many malpractice actions are brought as the result of some unwise statement made by the attending physician, or his partner, assistant, or office nurse, to the patient or to a friend of the patient. Care should be taken to avoid making any remark constituting an "admission" of fault, or one which may be construed as such. It is understandable that such remarks have been made under emotional stress or when exercising "hindsight" in the face of an unsatisfactory result even when good practice has been followed throughout. A single careless statement might create liability for damages where actually no liability exists. The effect of such a remark when reported to a jury is incalculable and almost impossible to counteract. Further, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony.

### Expert Testimony and Res Ipsa Loquitur

Generally, the proof of a physician's negligence must be established by the testimony of medical expert witnesses. The application of the doctrine of *res ipsa loquitur*[1] in a case gives rise to an inference of negligence on the part of the defendant, and relieves the plaintiff of the necessity of proving the alleged malpractice by the testimony of experts. It places on the defendant the burden of making explanation, if he can, to offset the inference of negligence; and by the majority rule a question is created for the jury, regardless of any and all evidence presented by the defendant.

The doctrine of *res ipsa loquitur* has been held applicable in the field of malpractice chiefly in cases which involve (1) slipping instruments, (2) sponges left in the tissues, (3) burns from heating modalities, (4) roentgen radiation injuries, generally limited to cases wherein the roentgen ray is being used diagnostically, (5) infection through the use of an unsterilized needle or instrument, and (6) injury to a portion of an anesthetized patient's body outside the field of treatment or operation.

[1] *Res ipsa loquitur* (literally, the thing speaks for itself) is a doctrine of the general law of negligence. It is held applicable whenever one person is injured by an instrumentality entirely in the control of another person, the use of which does not ordinarily result in injury if the person in control exercises due care.

### A Good Case Record is a Valuable Safeguard

The importance of good medical case records, as a factor in malpractice prophylaxis can not be overestimated. A good medical case record should contain a history[2] of the case and a physical examination of the patient, together with reports of all indicated laboratory studies. These data constitute the foundation of the medical record and will generally serve as the basis for at least a working diagnosis. If diagnosis is not possible, consultation is desirable. Consultation reports must be in writing. Thereafter, a good record will reflect (by means of progress notes) a sequential history of the case, its course, complications, and sequelae and, thus, the justification for further or changed investigation and treatment. Such a record will contain a statement of all treatment rendered in the case. Copies of special forms and of reports used or made in a particular case are also a part of a good record. It is desirable that an attending physician ask himself from time to time what he would wish to have in the record of the case under treatment in the event he should later be called upon to justify in court his conduct of the case. If a patient discontinues treatment before he should or fails to follow instructions, the record should show it. A good method is to file a carbon copy of the letter sent to the patient advising him against the unwise course.[3]

### Unwarranted Professional Criticisms Promote Malpractice Suits

The precipitating cause of a majority of all malpractice actions is found in the unwise comments or criticism of physicians with regard to treatment given to patients by other physicians. Commonly it is criticism by a succeeding physician of the work of his predecessor. Various authorities have estimated that 50 to 80 per cent of all the suits for malpractice would be eliminated if such destructive criticism could be stopped. It is profitless to attempt to determine why physicians are so prone to criticise destructively and unethically, but the results of it are deplorable. Legitimate criticism rests only on full knowledge of the facts as gathered from all parties; from the physician who treated the patient, as well as from the patient.

### Other Preventive Precautions

The importance of tact can hardly be overemphasized. It should be manifest especially in the handling of the patient and the patient's family; in the avoidance of fee disputes and unwise efforts and methods in the collection of fees (considering the provisions of the statute of limitations); in the avoidance of overoptimistic prognoses and especially of any promise constituting a guarantee of a par-

[2] It is important to indicate the source of the medical history (from the patient, member of family, etc.).

[3] There is a legal presumption that a letter mailed has been received by the addressee; but there is no presumption that a letter has been mailed.

ticular result; in the avoidance of betrayal of privileged communications; in the avoidance of making any statement constituting (or which might be construed as) an "admission" of fault or negligence; in the avoidance of any reference to malpractice insurance protection; and in the securing of legal advice before making any statement in regard to a malpractice claim or suit.

### Liability for Acts of Others

In addition to being responsible for his own acts and omissions, a physician encounters, in his everyday practice, instances in which he may also be responsible for the negligent acts and omissions of others. Thus, he is responsible for the acts of his assistants and employees, for their negligence occurring during the course of their employment. Where doctors practice as partners, each partner is liable not only for his own acts and those of his partner, but for the negligent acts of any agent or employee of the partnership.

When two independent practitioners are caring for a patient, each is liable not only for his own acts but for doing nothing about the negligent acts of the other which he has observed or which in the exercise of ordinary diligence he should have observed.

The attending physician is generally not liable for the negligence of an interne, a nurse, or other hospital employee. He is, however, responsible for the acts of the hospital personnel in so far as they are carried out under his immediate supervision and control. Thus, the operating surgeon and not the hospital is held liable for any negligence of operating room attendants during the performance of surgery.

### Consent for Operations, Treatment and Autopsies

Consent for operation must always be secured. Any adult in a clear state of mind may authorize operation upon himself. Oral consent might be considered sufficient; but because of the difficulty in proving that it was given, the physician should invariably require a witnessed consent in writing. If the patient is a minor (that is, a person under the age of twenty-one) consent is to be obtained from parent or guardian.[4] If the individual is mentally incompetent, the consent of the one who stands in the position of guardian is required.

When an operation is made compulsory by law (such as vaccination or sterilization[5]) the law furnishes the consent. If an operation is unlawful, consent to the performance thereof does not absolve the surgeon from liability.

In an emergency which demands immediate action for the preservation of the life or health of a patient and in which it is not practicable to obtain his consent or the consent of any one authorized to speak for him, it is the duty of the attending physician to perform without consent such operation as good surgical practice demands.[6]

If sterility is likely to result from the surgery which is contemplated, explanation of that probability should be made and a signed authorization obtained from both spouses. It should be borne in mind that it is hazardous to sterilize any person except upon a positive medical indication. Further, there should be no promise or guarantee that the patient will be sterilized as the result of the procedure undertaken.

The individual physician must secure consent to perform a postmortem examination. This, too, should be in writing[7] and sufficiently comprehensive to allow the removal and taking away of tissue if such is to be done.

The trend of the cases in recent years indicates that it is extremely unwise to pursue a course of treatment in itself hazardous or capable of producing harmful effect without securing a written statement from the patient, or from someone legally responsible for the patient—a statement which clearly expresses understanding of and consent to the special treatment.

### Failure to Use Recognized Diagnostic Aids

There are a large number of malpractice actions in the law reports which may be classified under the general heading of "Insufficient Treatment Cases." In every field of medical practice there are cases illustrating "insufficient care": the failure to make a blood count, a Wassermann, a pregnancy test, a culture, a smear, a urinalysis, a stool examination, an x-ray, original or follow-up; failure to make a complete diagnosis or overlooking a reasonably determinable condition; failure to utilize an indicated prophylactic measure (diphtheria, tetanus, etc.); the failure to give instructions, to follow up the original treatment or operation, to institute measures to protect contacts, etc., etc.

Failure to use the x-ray at all, or failure to make sufficient use of the x-ray, has been the chief allegation in many malpractice actions. Whenever a fracture is present which was not diagnosed and no x-rays were taken, the conduct of the attending physician is likely to be condemned as not coming within the standard of good practice.[8] Whenever a bad re-

[4] Statutory exception: In California a female of the age of 18 or more who is or has been married is an adult for the purpose of this consent.

[5] Under Eugenic Sterilization Statutes.

[6] 48 C. J. 1131; Jackovach v. Yocum (Iowa), 237 N. W. 444.

[7] In California, and several other states, it is criminally illegal for any person to perform an autopsy without having first obtained the written authorization of the coroner or other authorized public officer or of the person who has the right of disposition of the body.

[8] "The failure to make use of x-ray as an aid to diagnosis in cases of fracture amounts to a failure to use that degree of care and diligence ordinarily used by physicians of good standing in the community and the court, in absence of expert testimony, may take judicial notice of such fact." Agnew v. City of Los Angeles (Cal.), 218 Pac. (2d) 66.

sult, deformity or limitation of motion occurs, the defense is immeasurably strengthened by the possession of a series of x-rays taken at intervals during the progress of the case. Whenever a patient refuses to have an x-ray made, the physician should fortify himself with the strongest written evidence. X-ray records, as well as the entire case record, should be carefully preserved beyond the time during which a malpractice action may be brought.

The statute of limitations provides the period of time after which specified actions may not be brought. The time provided varies greatly in the several states. A physician should wisely inform himself of the situation in his own state.

### Obligations to Patients

To summarize, the physician who would understand his legal obligations, responsibilities, and duties to his patient, must constantly bear in mind the following fundamental obligations:

1. The physician must possess the degree of skill commonly possessed by other reputable practitioners in the same field of practice.

2. He must exercise the degree of care, diligence, and judgment commonly and ordinarily exercised by other reputable members of his profession in similar circumstances.

3. He must keep abreast of progress and follow good practice, common practice, in diagnosis and treatment; he must not experiment.

4. He must not neglect or abandon his patient; he must proceed diligently, without unnecessary delay.

5. He must give his patient sufficient attention and must utilize the indicated diagnostic aids.

6. He must find or anticipate any condition reasonably determinable or reasonably likely to develop.

7. He must obtain legal consent to operate and to perform an autopsy.

8. He must give proper instructions (that is, instructions consistent with the standard of practice) for the care of the patient in his absence, and for the protection of those coming in contact with the patient.

9. He must fulfil the terms of a special contract if he makes one.

The foregoing directions for reducing and avoiding the instigation of malpractice suits will not, of course, guarantee that a physician will not be sued unjustly; for already malpractice may be regarded as a contagious disease of the social body. There are several major reasons for this condition, but two are paramount: (1) the winning of a suit inevitably encourages the filing of others as patients become increasingly "suit conscious"; and (2) such suits are difficult to defend, and the knowledge of how best to conduct such a defense is not sufficiently widespread. The inter-relationship of these two points will be obvious; for each successful defense of an unjust suit will serve as a discouragement to the filing of others. But the second of these causes of high malpractice incidence—the difficulty of conducting a defense—is dangerously enlarged by many physicians themselves. Large numbers of medical men are naive enough to believe that their patients would never file such suits and that no precautions need be taken; and yet such precautions are the only assurance of the best possible defense in the event of a suit. The most vulnerable physicians are those who know that they are maintaining at least an average standard of practice and who are therefore (and blindly) assuming that they will not be sued. This discussion is concerned with *unjust* claims; no doctor who is actually guilty of malpractice should be allowed to go free of penalty. Meritorious claims should be settled out of court—preferably before a suit has been filed.

### Prompt Attention Should Be Given to Claims

Another too frequent hindrance to an adequate defense is delay in the investigation of claims; such delay is highly disadvantageous to the preparation of a defense. As a final word of warning that the physician may need every available precaution, one must consider the conditions under which most cases are heard. They are tried before juries made up of lay persons, and it is a truism that no one can say what a jury will do. This is particularly true of malpractice cases, for certainly lay jurors can not be expected to understand complex medical facts. How does a jury arrive at a decision when two expert witnesses testify that the defendant's conduct of the case did not meet the required standard, and two others declare that what the defendant did was consistent with the usual and ordinary practice in the community?

To physicians who have had little or no experience with the law and to lawyers who have little or no medical knowledge, the problem of adequately defending the unjust malpractice case seems insurmountable. And it is true that far too many such cases have been lost simply through poor defense. This is an aspect of the problem which needs a great deal more attention, particularly in areas which have become virtual "hot beds" of non-meritorious malpractice claims. At all times and to all physicians, there should be available expert advice on problems relating to the physician-patient relationship.[9] Whenever a threat is made against a physician, a carefully prepared procedure should be put into effect. Unjustified claims should be contested as thoroughly as possible. In such cases, it is sheer folly to compromise, on the theory that a slight settlement would be less expensive than the cost of defense. Such a course simply serves as an encouragement to others whose claims are not justified. This shortsighted view is largely responsible for the rapid increase in the number of malpractice claims in some sections of the country. If cases based upon unjust or absurd claims are permitted to receive even a slight profitable return, there will be an incentive to bring more of them.

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[9] Regan, L. J.: Doctor and Patient and the Law, St. Louis. The C. V. Mosby Company, 1949, chap. 20.

### Be Slow to Compromise

It is a great temptation to a doctor to rid himself of a nuisance claim by making a small settlement. The unfavorable publicity, the loss of time, and the mental and emotional strain involved in defending a malpractice suit may lead the physician to compromise. But, as is so often true, the easiest way out of a situation is seldom the best. For the sake of both himself and his colleagues, the doctor should make a determined opposition to an unjustified claim.

### A List of "Commandments" in Malpractice Prevention

In the final analysis, it is the physician himself who is responsible for the continuing existence of the vicious malpractice situation. The physician has generally been satisfied to pay his professional liability insurance premiums and thereafter to sit back complacently, doing nothing until he becomes a target for a malpractice claim. He must be brought to realize that his money payment is only a part of his insurance premium; a much more important part is his contribution of time, of study, and of putting into effect all possible measures to safeguard himself and his colleagues.

Prevention is the best defense against malpractice. Listed below are the 23 malpractice prophylaxis "commandments":

1. The physician should care for every patient with scrupulous attention to the requirements of good medical practice.

2. The physician must know his legal duty to the patient.

3. The physician must avoid destructive and unethical criticism of the work of other physicians.

4. The physician should keep "ideal" medical records in every case: records that would be presentable when offered in court; records that clearly show what was done and when it was done; records that clearly indicate that nothing was neglected and that the care given met fully the standard demanded by the law. If any patient discontinues treatment before he should, or fails to follow instructions, the record should show it; a good method is to file a carbon copy of the letter which advises the patient against the unwise course.

5. The physician should be careful to avoid making any statement which constitutes or which might be construed as an admission of fault on his part. Such an admission, which is usable against the physician, might be made to a third party as well as to the patient at any time before the trial. Such an admission may be made by an agent or employee of the physician during the course and within the scope of the employment. It is important to instruct employees to make no statements.

6. The physician should exercise tact as well as professional ability in handling his patients. A proper professional manner and a sound attitude should be maintained at all times toward both the patient and the patient's family. The attentive physician may early sense some unsatisfactory and disturbing under-current which, by the institution of protective measures, may be prevented from developing into something much more unpleasant. Thus, if the patient is not doing well, consultation may be suggested; if the patient is dissatisfied or complaining, or if the family's attitude indicates dissatisfaction, consultation should be demanded. The use of a consultant affords, in any case, great protection against a malpractice claim.

7. The physician should refrain from overoptimistic prognoses and should avoid promising too much to the patient.

8. The physician should advise his patients of any intended absence from practice and should recommend, or make available, a qualified substitute.

9. The physician should unfailingly secure written consent for operation and autopsy.

10. The physician should carefully supervise assistants and employees and take great care in the delegation of duties to them.

11. The physician should have some knowledge of the statute of limitations and of its significance.

12. In his selection of patients the physician should limit himself to such fields as are well within his qualifications. He should keep abreast of progress in the medical profession.

13. The physician should keep inviolate all confidential communications.

14. The physician should frequently check the condition of his equipment and make use of every available safety installation.

15. In the treatment of the patient the physician must not experiment.

16. The physician must be careful to render sufficient care to his patient in general instructions, frequency of visits, clinical and roentgen ray laboratory investigations and the like. Moreover, every precaution should be instituted for the protection of those caring for the patient and of all other contacts.

17. The patient must not be abandoned. The physician-patient relation can be terminated without liability only in certain ways and under certain conditions.

18. The physician should never reveal that he carries professional liability insurance. Except on the recommendation of his legal adviser, he should never write a letter or make any statement with reference to a malpractice claim. Immediately on being advised of even the possibility of suit, he should consult with his attorney.

19. The physician should arrive at an understanding in the matter of fees. Misunderstanding in this matter, particularly when the question of excessive fees arises, contributes an avoidable element of risk.

20. The physician should secure legal advice if he is called to attend a coroner's inquest as a witness in a case in which he has been in professional attendance.

21. The physician should realize that because of the possibility of error in transmission, it is dangerous to telephone a prescription.

22. The physician should realize that it is hazardous to sterilize any patient except when a medical indication exists.

23. Except in actual emergency, the physician should not examine a female patient unless a third person is present. There is no more serious or destructive charge than that of undue familiarity; and the only way to avoid claims of this sort seems to be to have some one else present during all examinations.

## Conclusions

There must be recognition of malpractice as a problem; that the conditions created by it are harmful to the physician and injurious to the public; and that action must be taken to correct it.

The public should be informed as to (1) what constitutes malpractice, (2) how really few cases of actual malpractice occur, and (3) the major degree of responsibility which the individual has in the maintenance of his own health.

Physicians must learn what they may do to safeguard themselves, and must put into effect every possible precaution against an unjust malpractice accusation.

## Addenda

**1. Consent to Operation**

Place _____
Date _____

1. I hereby authorize and direct Dr. _____ to perform the following operation upon me_____
_____
_____
and to do any other procedure that (their) (his) judgment may dictate during the above operation.
2. I understand that the surgeon (surgeons) will be occupied solely with the surgery, and that the administration and maintenance of the anesthesia are independent functions, and will be in charge of Dr. _____ I consent to the administration of such anesthetic, or anesthetics, as Dr. _____ may deem advisable in my case.
3. It has been explained to me that I may be sterile as a result of this operation, although no such result is warranted or guaranteed. I understand what the term sterility means and, in giving my consent to the operation, I have in mind the possibility (probability) of such a result.

A.M. Signed _____
Hour _____P.M. Witness _____

4. I join in authorizing the performance, upon my (husband) (wife), of the surgery consented to above. It has been explained to me that, as a result of the operation, my (husband) (wife) may be sterile.[1]

Date _____ Signed _____
A.M. Witness _____
Hour _____
P.M.

1. Cross out paragraphs not applicable to particular case.

**II. Consent to Operation upon Minor**

Place _____
Date _____

1. I (we) being the parent(s), guardian, custodian of a minor of the age of ____, do hereby authorize and request Dr. _____ to perform such surgical operation on the person of said _____, a minor, as the judgment of said Dr. _____ may dictate.

2. I (we) also authorize and request the employment of such anesthetic or anesthetics as may be deemed suitable in the judgment of the said Dr. _____, or in the judgment of the anesthetist selected to administer the anesthetic or anesthetics in this case.[2]

2. A similar consent form may, and should, be used in the case of a patient who is incompetent; signed by guardian, custodian, or other person legally responsible for the incompetent.

A.M. Signed _____( )
Hour _____P.M. _____
Witness _____

**III. Consent to Observers and/or Photographs and/or Televising**

In the interests of science and the furtherance of medicine, I, the undersigned, do hereby consent to and authorize _____ Hospital, and the Operating or Treating Surgeon and such doctors as may be assisting him, to examine and operate or treat me in the presence of other than the usual surgical staff.

I further authorize and consent to the taking of photographs and such subsequent use thereof as may be deemed advisable by said hospital and/or doctor, or doctors.

I further authorize and consent to the televising of any operative or other procedure performed or carried out upon me.

Dated _____ Signed _____
Witness _____ Witness _____

**IV. Patient Fails to Carry Out Advice**

*Note.* When a patient neglects or fails to carry out advice, it is desirable to have the facts established in writing. It may be wiser to withdraw from the case (See VII). This is a matter for the judgment of the physician in the particular case.

**SAMPLES[3]**

3. Substance of letter to patient to be changed to fit the particular facts and circumstances. Carbon copy, with proof of mailing of original written thereon, to be filed with medical case record.

Place _____
Date _____

**A.**
Name of Patient
Address
Dear Mr. _____:

At the time of my examination of your ankle this afternoon, I advised you of the desirability of having x-rays made. This you refused to do.

Upon your insistence that I treat your ankle and foot, without benefit of x-rays, I agreed to do my best in the circumstances, but as I advised you this afternoon, and must repeat now, I cannot establish, without x-rays, whether or not you have incurred a fracture.

In your own interest, I urge that you have an immediate x-ray study made of your foot and ankle.

Yours very truly,

**B.**
Dear Mrs. _____:

Upon the history you gave me and my findings on examination, both of this date, I am not able, as I told you at the time of your visit, to rule out pregnancy as the cause of the vaginal bleeding of which you complain.

You have told me that you will not submit to a pregnancy test. I again now advise you of its desirability. I hope you will come in tomorrow morning prepared, as I instructed you, to have the test made. If you continue to refuse to submit to this test, it will be necessary to have a consultant see you tomorrow, if I am to continue to advise you.

Yours very truly,

**C.**
Dear Mrs. _____:

When, in response to your call today, I saw your husband at your home, I told you my opinion was that he is very seriously ill with pneumonia, and that he should be immediately hospitalized. You refused to permit me to have him removed to the hospital. I told you that I am willing to do the best I can for him under the circumstances, but that he could be better cared for and he would be safer, with less likelihood of complication, in the hospital.

Your husband's condition is such that the matter cannot be discussed with him, so I hope that you will now, after giving the matter more thought, authorize his removal to the hospital.

Yours very truly,

**D.**
Dear Mrs. _____:

You brought your seven-year old boy in today for me to see. He has a deep, penetrating wound on the sole of his foot, apparently resulting from his stepping on a nail. You thought that it had been received in a neighboring stable.

I advised you that the boy should immediately be given an injection of tetanus antitoxin. You refused to permit me to administer this to him, stating that you had heard of two children who had severe reactions following such prophylactic treatment.

I told you that I would make a preliminary test which would warn us of the likelihood of severe reaction, but that I could not guarantee that result or any result. You reiterated your refusal.

I cannot give the boy this treatment, or any treatment, without your consent. I urgently recommend that you permit me, or some other physician of your choice, to administer a preventive dose of tetanus antitoxin to your boy without further delay.

Yours very truly,

### V. Patient Fails to Keep Appointment

**SAMPLES[4]**

4. When a patient fails to keep an appointment, or discontinues treatment before he should, it is desirable to send him a letter, incorporating the pertinent facts and the recommendations. File a carbon copy, endorsed with a certificate of mailing, with medical case record. Registered mail may be used.

Place _____
Date _____

**A.**
Name
Address
Dear Mr. _____:

My records indicate that you failed to keep your appointment of _____ (date), and that you have not made any subsequent appointment or appearance in the office.

In your own interest, may I call to your attention the fact that further professional attention is, in my opinion, definitely needed. If there is some reason why you prefer not to return to this office, I urge that you immediately seek other competent professional care. I shall be glad to give the benefit of my knowledge of your case to your subsequent physician, should you elect to receive the needed attention at other hands.

Yours very truly,

**B.**
Dear Mrs. _____:

You have not returned, as arranged, since, at your request, I examined you on last Friday.

The history you gave of "spotting" between periods over the last several months, and my findings on examination, which I related to you, are of such significance that, as I endeavored to impress upon you when I made an appointment for you to return with your husband, I must urge upon you the advisability of having immediate medical attention.

If you do not wish to return to me, you should consult another physician at once.

Yours very truly,

**C.**
Dear Mrs. _____:

You failed, again, today to appear in accordance with your appointment at the Radiologist's office so that a check-up x-ray could be made of your fractured wrist.

I have previously urged upon you the necessity of having your cooperation to improve the likelihood of a favorable result.

You should not be heard to complain of the end result, if it is not satisfactory, when you refuse or neglect to follow the advice of your physician.

I now request that you appear at my office at ten o'clock tomorrow morning. I am arranging to have x-rays made at that time and to have a specialist in orthopedic surgery see your arm.

Yours very truly,

### VI. Patient Discharges Physician From Case[5]

5. If a physician justifies his failure to continue in attendance upon a patient upon either his having withdrawn from the case or of having been discharged by the patient, the burden of proof of such contention is upon him—hence the desirability, if not the actual necessity, of having written evidence available.

Dear Mr. and Mrs._____:

This is confirmation, and my acknowledgment, of the fact that you have, as of this date, discharged me from further professional attendance upon you in your current illness.

Should you desire, I shall be glad to cooperate with the physician you now call, in supplying him with such information as I have gained in respect to your case.

Yours very truly,

### VII. Physician Withdraws From Case

*Note.* A physician may withdraw from attendance upon a patient, but he must give reasonable notice of his intention to do so and must allow the patient reasonable time and opportunity to fill his place. If the fact, whether a physician did withdraw from professional attendance upon a patient, became an issue in the case the burden of proof falls upon the physician. For this reason, it is desirable that written evidence be available.

It is a serious question of judgment, whether, when a patient fails to cooperate or refuses to follow advice, the physician should continue on the case. It is recommended that, if the physician decided to continue to care for an uncooperative patient, who, for example, refuses to have an indicated x-ray study made, he should demand and require consultation.

**SAMPLES[6]**

6. Letters should be sent and carbon copy filed. The wording should be simple and direct, but the intent and meaning must be clear and certain.

Place _____
Date _____

**A.**
Name
Address
Dear Mr. _____:

You have repeatedly failed to follow my advice and recommendations.

I am therefore advising you of my intention to withdraw from further professional responsibility in connection with your case. To allow you a reasonable opportunity to secure another physician, I shall be available, at your request, to render you service for three days from your receipt of this letter, but not thereafter. In this period of time, in this community of several hundred physicians, you can readily fill my place.

I shall be glad to give, to any reputable physician of your choice, the benefit of such knowledge as I have gained of your case.

Yours very truly,

**B.**
Dear Mr. _____.

You consulted me this afternoon in connection with an injury to your foot and ankle. At that time, upon your refusal to have x-rays made of the injured area, I advised you that I could not undertake to render professional service to you.

So that there may be no misunderstanding, I am confirming these facts in writing.

Yours very truly,

**C.**
Dear Mrs. _____:

As I told you this morning, I cannot longer continue to be professionally responsible for the care of your little boy. This decision is necessitated by the fact that you have repeatedly refused to permit me to make the detailed and thorough study of his condition which I regard as indicated and vital.

Please secure other medical attention at once. In the meantime, and for a reasonable time, I shall remain available, at your request, to render any routine or emergency service that may be required.

I shall, of course, be glad to offer to Tommy's new physician the knowledge of his case which I have been permitted to acquire.

Yours very truly,

**D.**
Dear Mrs. _____:

You failed to keep your appointment this week.

At the time you received your injection last week a portion of the needle broke off in your tissues. You were at once advised of this accident. As I told you, after preliminary search, I was unable to recover the broken piece without anesthesia and incision, and recommended that localization studies be made prior to undertaking definitive search.

I again recommend that procedure and will make arrangements at your request and responsibility.

Yours very truly,

# Wisconsin Interscholastic Athletic Association Accident Benefit Plans

THE purpose of this article is to provide basic information for physicians in Wisconsin who are frequently called upon to handle accidents arising out of interscholastic athletic events and also accidents arising out of other school activities.

One of the principal functions of the W.I.A.A. is the accident benefit plan which is solely operated by the organization. This benefit program provides enrolled pupils in member schools indemnity benefits to assist in meeting the cost of medical, hospital, and dental care in the event of accidental injury. The plan also provides a principal sum benefit in the event of death.

The W.I.A.A. was a pioneer in offering low cost accident coverage to students. Beginning in 1930, its program now offers protection for athletes and pupils from kindergarten to the 12th grade. The plan provides benefits only when treatment has been rendered by licensed physicians and surgeons or dentists. The plan pays for consultation and referral services only when they are authorized by the physician in charge of the case.

The plan's benefits are of an indemnity nature only, and physicians are urged to understand that in no event should the payment be construed as full payment unless the physician himself is willing to accept it as such.

The State Medical Society has cooperated with the W.I.A.A.'s Benefit Plan since its inception. An advisory committee of the Society operates to provide a means to arbitrate disputes and render medical advice to the program.

## Claims Procedure

When an accident is covered by the plan, it is the responsibility of the school to report the accident within 12 days to the W.I.A.A. in order to obtain authorization for treatment for the injury. The school principal should furnish an authorization blank to the pupil which may be, if desirable, signed by the physician in charge of the case. In any event, whether the authorization is first sent to the W.I.A.A. by the principal, or signed by the doctor and then mailed, it must be postmarked not later than 12 days following the injury in order that the student may be eligible for benefits. Upon receipt of the Authorization for Treatment Form, the W.I.A.A. office mails to the school all the necessary forms. One of these forms is a report or claim blank. The school forwards this blank to the physician, and he is expected to complete the blank and return it to the school. The claim blank asks for the following information: the nature of the injury, a description of the treatment, predisposing factors contributing to the injury, and a prognosis.

Benefit claims will be valid and compensable only when the athlete remains out of all athletic activity, including practice and games, for the number of days indicated in the schedule below:

| *Injury* | *Required Reduction* | *No Reduction* |
|---|---|---|
| Cuts, medical attendance benefits, and all others | | 5 days |
| Broken nose, hand, foot, rib, or dislocated fingers | 12 days | 6 days |
| Dislocations, aspirations, or separation of joint | 30 days | 15 days |
| Injuries to kidneys—contusion | | 30 days |
| Broken bones | 60 days | 30 days |
| Skull injuries (concussion with hemorrhage) | 1 year | 1 year |
| (Minor concussion—no hemorrhage) | | 30 days |
| Injuries to knee, involving cartilage or joint structure | 60 days | 60 days |
| Rupture of viscus requiring surgery | 1 year | |

## Levels of Coverage

The protection offered to students is identical regardless of the method obtained and premium paid. The *Pupil Benefit Plan* provides coverage for pupils in all grades from kindergarten through the 12th grade. This protection covers every injury incurred while the student *is engaged in a school activity in the classroom, on the playground, in the gym, in the shop, and in the laboratory.* The cost of the *Pupil Benefit Plan* is 50 cents per pupil per year.

The other program is called the *Athletic Benefit Plan,* and it is in two parts: (1) coverage for all sports, costing $2.50 per school year; (2) coverage for all sports *except football,* costing $1.25 per school year. Experience has indicated that the accident ratio arising out of football is much greater than that arising out of any other type of competition. The school administration usually assumes the cost of these programs. A student may, however, lacking financial support from the school, pay his own premiums provided the school is a member of the W.I.A.A.

## Schedule of Allowances

No attempt will be made here to set forth the dental regulations or dental allowances for treatment in the event of injury to the teeth.

Because of space limitations the schedule of benefits relating to treatment for fractures and dislocations is not printed here. That schedule is available upon request to either the W.I.A.A. office or the office of the State Medical Society.

### Miscellaneous

| | |
|---|---|
| Entire sight of one eye if irrevocably lost | $200 |
| Partial loss of sight of one eye (seriously handicapped) | 100 |
| Concussion | 20 |
| Injury to viscus requiring surgery | 150 |
| Suture of laceration (an additional $1 will be allowed for each suture over one) | 5 |
| Lacerations (not requiring sutures) | 5 |
| Tetanus anti-toxin | 3 |

| | |
|---|---|
| Sprains—Joints of hands or foot | $ 5 |
| Joints of wrist, shoulder, ankle, knee, elbow, back | 10 |
| Abrasions | 5 |
| Aspirations | 5 |
| Fluoroscope Examination | 3 |

**Medical Attendance** Maximum $12

If an injury does not come under the above schedule of allowances but requires treatment by a legally qualified physician or surgeon within 12 days of injury, not including treatment on the field at the time of play or practice, an allowance will be made with the maximum of $12.

**Hospital Benefits** Maximum $96

Hospitalization benefits are allowable in connection with the following injuries: cerebral hemorrhage, concussion, fractured vertebrae, fractured leg, fractured jaw, compound fracture of the arm requiring frame and weights, knee injury requiring surgery, ruptured viscus, or other serious internal injury. To be compensable the confinement must be for a period of 12 hours or more in a recognized hospital. The maximum daily allowance is $8, not to exceed 12 days. The maximum hospital allowance is limited to $96.

**Principal Sum** Maximum $400

The principal sum benefit is limited to actual expense incurred in connection with the death and burial but will not exceed $400. In order to qualify for the principal sum benefit, evidence must definitely establish that the death was directly attributed to the accident; that the death occurred within ninety (90) days of the date of the accidental injury; and that all requirements for participation have been complied with.

**Serious Injury Provision** Maximum $400

If the expense incurred for necessary medical and dental care exceeds by one hundred dollars ($100) the benefit for the injury as provided in the schedule of allowances, the Wisconsin Interscholastic Athletic Association will pay the amount in excess of the above $100. The total amount of the payment by the Wisconsin Interscholastic Athletic Association for injuries resulting from one accident shall not exceed $400.

## Exclusion from Coverage

The plan makes the statement that it is not a "health protection plan" and therefore will not make payment for injuries which are not the direct result of an accident. Benefits are not provided for cases resulting from congenital weaknesses, from violation of required safeguards, and from disregard of safety measures. No benefits are allowed for the following items:

Hernia
Boils
Blisters
Skin infections
Recurrent dislocations
Athlete's foot
Broken glasses
Orthopedic appliances
Medicines and bandages
Ambulance service

Since the plan first went into operation in the early 1930's, total receipts under the athletic division have amounted to $554,300.72. In the same period authorized claim payments were $670,057.83. The difference between the receipts and the claims paid amounted to $115,757.11. This latter amount of money represents a subsidy contributed by the W.I.A.A. from income derived from the state basketball tournament series. During the 23 years of operation of the benefit plan, 829,000 students have been covered for athletic events. The Pupil Benefit Plan has been in operation for only 8 years. There are currently 275,000 pupils covered under this plan.

## Preliminary Physical Examination

Students who are covered by either the all sports category or the all sports except football category must first obtain a physical examination to determine eligibility for the program. The W.I.A.A. urges the athlete to have his family physician make this examination. The W.I.A.A. provides no benefit defraying the cost of this examination, and any charge made by the physician is the liability of the student himself.

If a physician has a question concerning the benefit plans of the W.I.A.A., he may write directly to the W.I.A.A. office in Marinette, Wisconsin (Clifford B. Fagan, Executive Secretary), or he may direct questions to the State Medical Society office.

# YOUR DEADLINES AND OTHER "MUSTS"

Below are some of the deadlines and "musts" of a practicing physician:

Taxes.

1. File your Wisconsin and federal income tax returns as early in 1954 as possible, *but not later than March 15.*

2. By January 15, 1954, you must pay the final installment of estimated 1953 tax. By this date you must have paid at least 80 per cent of the tax which will be actually due for 1953. If it appears that you will not be within 80 per cent, you may file an amended declaration for 1953 by January 15, 1954, and pay an amount sufficient to bring you within 80 per cent. In lieu of such amended declaration, you may make your federal tax return on that date and pay the full balance due.

3. By January 31, you must:
   (1) File the employer's final return of income taxes withheld in 1953 on Form W–3.
   (2) Furnish a statement to employees on Form W–2 showing wages paid and amount of tax withheld during the calendar year 1953.
   (3) File fourth quarterly return for 1953 of income and social security tax withheld on wages paid employees on Form 941:
      a. If entire tax not paid by timely depositary receipts.
      b. If less than $100 withheld in each of October, November, and December 1953.
   (4) Pay income and social security taxes withheld on 1953 wages to employees:
      a. If more than $100 withheld in December 1953, and not paid to government depositary earlier in January 1954.
      b. If less than $100 withheld in each of October, November, and December 1953.

4. (1) If instructions contained in paragraphs 3 and 4 of Section 2, preceding, are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31 for the respective preceding calendar quarters.
   (2) If the instructions contained in paragraphs 3 and 4 of Section 2, preceding, are not applicable to your case, in other words, if the total of income and social security taxes withheld on employees' wages exceeded $100 a month and timely deposits for that purpose were made in each of the three preceding months, a quarterly return on Form 941 is due and should be filed on February 10, May 10, August 10, and November 10.
   (3) If income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to a government depositary by the fifteenth of the following month. The amount of such withheld taxes for the last month of each quarter may either be paid the month immediately following or by the tenth of the second month after the ending of such calendar quarter, as earlier set out in these instructions.

5. The first quarterly estimate of your own income for 1954 is due on March 15. Further estimates are due by June 15 and September 15 of 1954 and January 15, 1955. On those dates you may also amend your March estimate, if there has been a substantial change in your income. By January 15, 1955, you must have paid at least 80 per cent of the tax which will be actually due for 1954. If it appears that you will not be within 80 per cent, you may file an amended declaration for 1954 by January 15, 1955, and pay an amount sufficient to bring you within 80 per cent. In lieu of such amended declaration, you may make your federal tax return on that date and pay the full balance due.

Annual Registration in Wisconsin; Annual Narcotics Registration

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners in the month of January. This registration will be on a form furnished by the Board of Medical Examiners.
2. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1954. You are subject to penalties for overlooking either the registration or the tax.

Change of Residence:

1. Notify the collector of internal revenue to insure the legality of your narcotics license. Penalties are imposed for failure to do this.
2. If you take up residence in another county, record your license and basic science certificate with the county clerk so that no question will arise as in the collection of your fees, or your right to give testimony in a legal proceeding.

Remember to:

1. Make prompt report to the State Board of Health of cancer cases, communicable diseases and others as described in the article on page 79.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30, statutes.

3. Register with the county judge if you desire reference work on commitment proceedings for persons allegedly insane, epileptic, inebriate, mentally deficient, and drug addicts. Registration is limited to physicians who have practiced for two years, or have had one year's experience in a hospital for the insane. Sec. 51.01 (2), statutes.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.
5. Report immediately to the local health officer in writing the name, age, and address of every person diagnosed as afflicted with "epilepsy or similar disorder characterized by lapses of consciousness." Section 146.23 (2), statutes.
6. Report *immediately* the following deaths, as required by Section 366.20, statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:

   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate. See page 43.

## PHYSICIANS ADVISED ON SUBSTITUTION OF SILVER NITRATE

Attention has been directed to the fact that some Wisconsin physicians are reporting on birth certificates the use of penicillin as a substitute for silver nitrate in the prevention of opthalmia neonatorum. While there has been some discussion in professional circles regarding the efficacy of substitutions for silver nitrate, the Committee on Maternal and Child Welfare has expressed the opinion that to date there is insufficient evidence to support such action. Physicians are urged to subscribe to the procedures clearly set forth in the Wisconsin Statutes, which reads:

> "146.01 Infant Blindness: (1) For the prevention of opthalmia neonatorum, or blindness in the new born babe, the state board of health shall, annually, cause to be prepared and put up in proper containers a one per cent solution of nitrate of silver with instructions for its use. These shall be distributed free to local health officers in quantities sufficient to enable them to, and they shall, deliver one to each physician and midwife. The attending physician or midwife shall use the said solution as directed in said instructions.
>
> * * *
>
> "(3) Any person who violates this section shall be fined not more than one hundred dollars."

On the basis of present procedures set up through the State Board of Health, and the reliable services of the State Laboratory of Hygiene in supplying solutions of correct strength and freshness, it does not appear advisable to the Committee on Maternal and Child Welfare to suggest revision of the Wisconsin statutes at the present time.

Until such time as the wording of the law is changed, physicians are warned to avoid the use of any substitute for silver nitrate in the prevention of opthalmia neonatorum, as violation of the statutes subjects a physician to a possible fine, as indicated, and may subject him to a suit for malpractice.

The position adopted by the committee concurs with that of the American Medical Association as was stated in an editorial which appeared on page 123 of the January 12, 1952, edition of the Journal of the American Medical Association.

# The Student Loan Fund

THREE medical students enrolled in Wisconsin schools of medicine were recipients of financial assistance through the Student Loan Fund of the State Medical Society of Wisconsin during 1953. Several other students have pending applications. Although the fund is now actually functioning to fulfill its purpose of helping youthful aspirants to the profession of medicine achieve their goal, there is every indication that it is far from achieving its potential. It is reported that "at least half" of the 600 medical students in the two Wisconsin medical schools could use some financial help. About one third are said to need complete support. With medical education now requiring more and more devotion to studies, and with the yearly cost of such education ranging from $1,200 to $1,750, the Student Loan Fund promises to fill a great need.

The Student Loan Fund grew out of a proposal by Dr. H. H. Christofferson, Colby, at his inauguration as president of the State Medical Society in October, 1950. The fund was organized in August, 1951, at the initial meeting of its Board of Trustees. Their goal is the accumulation of a $250,000 fund to provide assistance to needy and deserving medical students.

The fund is a trust administered by a board of seven trustees. Four trustees are the president, president-elect, chairman of the Council and secretary of the State Medical Society who serve as trustees during their terms of office as such officers of the Society. These trustees select three additional trustees, one of whom must be a physician.

Present board members are: H. Kent Tenney, M.D., Madison, chairman; the Honorable A. Matt Werner, Sheboygan, vice-chairman; C. H. Crownhart, Madison, secretary-treasurer; Ira R. Sisk, M.D., Madison; R. G. Arveson, M.D., Frederic; A. J. McCarey, M.D., Green Bay; and the Honorable Oscar A. Rennebohm, Madison.

The fund will be used to provide assistance in the form of loans, with preference given to students enrolled in the University of Wisconsin Medical School or Marquette University School of Medicine.

## Who Is Eligible

Residents of the State of Wisconsin who are presently enrolled, or about to enroll in a class "A" medical school, are considered eligible to apply for a loan. The Board may also grant loans to residents of the state who have received their M.D. degree and are fulfilling the requirements of an internship. Neither premedical students nor residents are eligible for loans at this time.

The applicant must demonstrate to the board's satisfaction that he is in need of financial help, and that such financial help is essential to his medical education.

Applications for student loans must be made directly to the Board of Trustees of the Student Loan Fund.

## Loan Limits and Security

A loan may be made in any amount not to exceed $1,000. The applicant may apply as many times as he sees fit, and may obtain more than one loan as long as the total obligation does not exceed $3,000. Loan money will be advanced to the borrower as needed, within the maximum.

Loans are to be repaid within three years of the time the student receives the degree of Doctor of Medicine. If the student severs himself from his medical education prior to receiving the degree, the board may require repayment at an earlier date.

Any interest on the loan is waived until borrower's licensure following the completion of internship or until he has disassociated himself from a medical school voluntarily or otherwise. Where the withdrawal from medical school is temporary, as for example for reasons of health, interest will be suspended during such temporary withdrawal as long as it does not exceed one year. Interest will also be suspended while a borrower is in active military service.

The board is also empowered to suspend interest or extend the maturity date of the loan to fit special circumstances. In no case may interest charges exceed 4 per cent per year. The following interest charges may be applied:

1. Two per cent if paid within one year following licensure.
2. Three per cent if paid during second year following licensure.
3. Four per cent if paid after two years from date of licensure.

Applicants for loans are subject to interview by members of the Board of Trustees. The board must make annual reports to the Council of the State Medical Society and will make other reports at its discretion.

To date, $3,000 has been made available to an applicant or applicants from Marquette University School of Medicine and the same amount to an applicant, or applicants, from the University of Wisconsin Medical School, subject to the following conditions:

1. Applications are to be approved by the deans of the two medical schools.
2. No loan is to be granted for the purpose of consolidating an applicant's pre-existing indebtedness.

3. Any loan without the maximum stated above shall be based on total needs of the applicant for the balance of his educational period, including his year of internship. For example, if an applicant estimates that for the balance of his period of education he shall require a total of $1,500 but at the rate of $500 a year, then $1,500 shall be earmarked for that applicant and made available to him at the rate of $500 a year.

The Board of Trustees does not feel warranted in making more of the fund available for loans until the size of the fund is increased.

Physicians are urged to make contributions or bequests to the fund. Checks should be made payable to THE STUDENT LOAN FUND, STATE MEDICAL SOCIETY OF WISCONSIN, 704 E. Gorham Street, Madison 3, Wisconsin. Contributions are deductible in computing taxable net income on both federal and state returns. A contribution blank which may be clipped and filled out by a contributor and attached to his contribution is set forth below.

Any person desiring to leave a portion of his estate for the perpetuation of the fund is urged to designate the bequest according to the following form:

"I hereby give, devise and bequeath to the Student Loan Fund of the State Medical Society of Wisconsin, 704 E. Gorham St., Madison 3, Wisconsin, the sum of _____ dollars to be used for the objects and purposes of the fund."

Every contribution to the fund will be gratefully appreciated. Inquiries or other evidences of interest in the fund may be directed to the State Medical Society or the Board of Trustees at any time.

THE STUDENT LOAN FUND
STATE MEDICAL SOCIETY OF WISCONSIN
704 E. Gorham St.
Madison 3, Wisconsin

I hereby give the sum of $_____ to be used for the objects and purposes of the Student Loan Fund.

Name _____

Address _____

## AMERICAN COLLEGE OF SURGEONS OFFERS SCHOLARSHIPS IN FIELD OF RESEARCH

The board of regents of the American College of Surgeons has announced the establishment of scholarships in the field of research for young men seeking a career in academic surgery who have recently finished or are in the final months of their residency training program.

In May the college established one of these scholarships. It is planned that additional scholarships will be added through the efforts of Fellows and various organizations interested in this project.

Candidates must obtain the approval of the chairman of the department of surgery and dean of the same medical school and the authority of an executive officer of the university making the proposal.

Successful candidates will receive $20,000 over a three-year period, to be divided as follows: $6,000 for the first year, $6,000 for the second year, and $7,500 for the third year. The institution or medical school sponsoring a successful candidate may supplement this amount with the permission of the committee on selection of the American College of Surgeons.

Medical schools or institutions supporting the nomination of a candidate will be required to provide a satisfactory place to work, with adequate facilities, as well as funds with which to support necessary research.

The candidate and the institution supporting his nomination are asked to supply the college with a planned program for the nominee. On completion of the research scholarship, the medical school or institution supporting the candidacy of the nominee is expected to absorb the research scholar into its faculty and to support him on a full-time basis with its own budget.

Inquiries may be addressed to the Research Scholarship Committee, American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

# University Hospitals

IN ORDER to properly characterize and at the same time to avoid confusion, the single term, University Hospitals, is presently being used with the following designated units included under this grouping.

Student Infirmary
Mary Cornelia Bradley Memorial Hospital
State of Wisconsin General Hospital
Wisconsin Orthopedic Hospital for Children
Cancer Research Hospital

According to the provisions of chapter 142 and section 36.31, Wis. Stats., the State of Wisconsin General Hospital, located in Madison, was established for two primary purposes: (1) to furnish facilities for teaching and the advancement of medical knowledge; and (2) to furnish specialized facilities for the care and hospitalization of patients lacking such facilities within their own communities.

142.01 Public patients. (1) A person having a legal settlement in any county in this state who is crippled or ailing and whose condition can probably be remedied or advantageously treated, if he or the person liable for his support is financially unable to provide proper treatment, may be treated at the Wisconsin general hospital or the Wisconsin orthopedic hospital for children at Madison or in such other hospital or rehabilitation camp as the county judge shall direct, except that when the person to be treated, or his guardian if he be under guardianship, shall select that such treatment be at the said Wisconsin general hospital or the said Wisconsin orthopedic hospital or rehabilitation camp, the hospital or rehabilitation camp of his selection shall be the place of treatment; provided that the right of such selection shall not exist in counties having a population of five hundred thousand or more . . .

142.02 Application. When the case of such person shall come to the notice of the sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physician or surgeon, or any public official, he shall and any teacher, priest or minister may, file with the county judge of the county wherein such afflicted person has a legal settlement an application for such treatment at such hospital.

The judge then appoints a physician to investigate the physical condition of the patient. At the same time the judge makes an investigation as to the propriety of such a commitment. The supervisor of the town, village or ward of residence of the person is required to furnish the court, upon request, with all material information within his knowledge in order that the judge may intelligently decide the case. If the judge is satisfied that the patient or the person liable for his support is financially unable to provide proper treatment and upon recommendation of the physician that the patient is a proper person for hospitalization at the State of Wisconsin General Hospital, the judge shall then issue an order approving such hospitalization, in which instance the cost is borne equally by state and county, provided that the county has not exceeded its quota for that year.

Unless the case is an emergency, the hospital desires the court order certifying the patient to the institution prior to the arrival of the patient. This allows the hospital to delay admission in certain cases where the services are already overcrowded.

Patients are also admitted to the hospital upon receipt of a letter from the family physician stating that the patient can pay $17.00 a day, in advance, for hospitalization, but that a professional fee or extras in addition would be a severe hardship. A few private cases are also admitted, but the hospital is not primarily interested in this type of work. Address all communications to the office of the Superintendent, 1300 University Avenue, Madison, Wisconsin.

Classification of patients admitted to the hospital is given below:

1. *County-state patient:* Hospitalization is authorized by the county judge of the county in which patient resides. Hospitalization costs are paid equally, half by the county and half by the state until that county's quota for that year is exhausted in which case the county bears the full cost.

2. *Special rate patient* (formerly called the "clinic case"): This type of patient comes to the hospital on his physician's recommendation that he be accepted on $17.00 per day basis. A financial statement of the patient is taken on admission, and if it is felt that his status justifies a $17.00 per day charge, he is admitted on that basis. He is thereby entitled to every service except transfusions and special nursing.

3. *Private patient:* This type of patient is handled the same as would be the case in any other hospital *except* that he is accepted only on reference or recommendation of the physician in the home community.

4. *War Veterans:* Any honorably discharged veteran of any war of the United States, who has been a resident of the state for not less than five years preceding his admission, may be admitted to the hospital and obtain all care including professional service at the established per diem rate ($5.90). War veterans are required to present their honorable discharge papers and sign a statement declaring residency for the last five years preceding admission to the hospital. War veterans may be admitted as private patients of individual staff members if properly referred, in which case hospital rate is as above, but professional fee applies.

Patients are also seen in the Outpatient Department of the Hospitals upon reference from the family physician or official agency. Registration fees for most outpatient clinics follow:

| | |
|---|---|
| Public Patient | $ 1.00 |
| Special Rate Patient | 5.00 |
| Private Patient | 5.00 |

These fees cover the hospital charges *only* and do not include professional fees if they are applicable.

A similar schedule of fees for the Tumor Clinic has been established.

For the Easter Seal Cerebral Palsy Center, the fees are as follows:

| | |
|---|---|
| Public Patient | $ 1.00 |
| Special Rate Patient | 7.50 |
| Private Patient | 15.00 |

**No patient is accepted at Wisconsin General Hospital unless referred or recommended by the patient's physician, except in case of emergency or accident where delay may cause serious complications.**

## Units of University Hospitals

*State of Wisconsin General Hospital:* Admissions per above; general hospital service plus teaching privileges in connection with the University.

*Wisconsin Orthopedic Hospital:* Orthopedic and plastic surgery patients only. All patients admitted through the regular admitting channels of the Wisconsin General Hospital and with the approval of the Crippled Children's Division.

*The Mary Cornelia Bradley Memorial Hospital for Children:* This is the Pediatric Department of the State of Wisconsin General Hospital and is not a separate unit.

*University of Wisconsin Student Infirmary:* Student health center and hospital.

*Cancer Research Hospital:* An integral part of the additions to the State of Wisconsin General Hospital, dedicated by the National Institutes of Health in January 1952.

*Wisconsin Psychiatric Institute:* The laboratory facilities of the Psychiatric Institute have been taken over by the State Laboratory of Hygiene. The other functions of the Institute will be incorporated in the Diagnostic Center which is presently being erected.

### Treatment May Be at Home or in Local Institution

Under the Wisconsin General Hospital Law (sections 142.01 and 142.04) a person having a legal settlement in any county, who is crippled or ailing and whose condition can probably be remedied or treated advantageously, and for whom treatment is financially impossible, may be confined, as the situation warrants, in the Wisconsin General Hospital, in the Wisconsin Orthopedic Hospital, in a local institution or at home.

### Conditions Necessary to Local Treatment

Where treatment is to be given at home or in a local institution, the court must find that such treatment will be adequate and at the same or less expense to the county. But it must be kept in mind that the law is beneficent, and must be construed to give effect to its purpose. And in the consideration of "expense," the county judge may take into account the costs necessary to remove a patient to Madison, for transportation expense, and those of an attendant, both to and from the institution, are not items of joint state and county expense.

### The County Quota

Under the provisions of the law, state aid ceases when the total county patients committed from any one county exceeds a ratio of more than two persons per thousand of population or major fraction thereof, although there is no limit if there is no hospital in the county concerned nor as to patients certified to the Wisconsin Orthopedic Hospital. The decision whether there is a hospital in the county is for the secretary of state at the time he certifies to the county its share of the costs. 30 Atty. Gen. 98. If the county exceeds its quota, then the county must pay the entire cost of hospitalization if the patient is to be confined in Madison. If the patient is confined at home under the provisions of the law, no expense of hospitalization is involved at all. The only expense to the county would be that of medical care and nursing.

### Physicians' Fees

In proceedings under the Wisconsin General Hospital Law, two entirely separate and distinct fees are permitted physicians.

By provisions of section 142.03 (2) the county judge, if satisfied that a patient presents a proper situation, "shall appoint a physician personally to examine the person." By statute, the physician is directed to make a verified report in writing giving certain required information, and shall "be paid by the county $5.00 and actual and necessary expenses." Since no method is provided for the payment of the physician, he must proceed through legal channels for the collection of the $5.00 fee allowed. Following the provisions of section 59.77 (1), dealing with claims against the county, the physician must make a statement of his claim in writing upon county voucher forms setting forth its nature and the facts upon which it is founded. If the claim includes mileage, the statement should specify the days and places, so as to show between what points, and when, and the purpose for which the travel charges were made. Since the fee is statutory, the time expended in the performance of service need not be stated. But the statement must be verified by affidavit and filed with the county clerk, whose duty it is, under the provisions of section 59.79 to transmit the same to the county board.

The expense of treatment of such patients, in local institutions or at home, shall be paid by the county treasurer, upon the certificate of the county judge who shall be satisfied as to the correctness and reasonableness thereof. The claim of the physician rendering the treatment need not be passed upon by the county board, but only by the county judge. See sections 142.04 and 142.08 (5). See also 21 Atty. Gen. 240 and 22 Atty. Gen. 408.

## 1954 POSTGRADUATE CIRCUITS ANNOUNCED

The Council on Scientific Work, in cooperation with the State Board of Health, the Wisconsin Academy of General Practice, the two medical schools, and the state voluntary health agencies, announces a new series of three-day circuit teaching programs, beginning in March and ending in June.

Complete details will be announced in the February *Journal* and through a special mailing to members who participated in the 1953 programs.

The dates and speakers are as follows:

1. MARCH 16: MONROE MARCH 17: KENOSHA MARCH 18: PORTAGE

Speakers: Edward Allen, M.D., Chicago (obstetrics)
Thomas V. Geppert, M.D., Madison (pediatrics)
Mischa Lustok, M.D., Milwaukee (cardiac drugs)
Alfred Uihlein, M.D., Rochester, Minnesota (head injuries)

2. "RELATED DISEASES OF THE CHEST"
APRIL 13: EAU CLAIRE APRIL 14: STEVENS POINT APRIL 15: APPLETON

Speakers: Helen Dickie, M.D., Madison (fungus diseases of the chest)
Thomas Dry, M.D., Rochester, Minnesota (pulmonary changes in cardiac disease)
S. A. Morton, M.D., Milwaukee (radiology)
J. D. Steele, M.D., Milwaukee (suppurative diseases of the chest)

3. APRIL 27: PLATTEVILLE APRIL 28: OCONOMOWOC APRIL 29: MANITOWOC

Speakers: Fred Hofmeister, M.D., Milwaukee (obstetrics)
Robert Jackson, M.D., Iowa City (pediatrics)
Howard Root, M.D., Boston (diabetes)
Herman W. Wirka, M.D., Madison (fractures)

4. MAY 25: CHIPPEWA FALLS MAY 26: IRON RIVER (Pinecrest) MAY 27: RHINELANDER

Speakers: Garrett Cooper, M.D., Madison (dermatology)
E. J. De Costa, M.D., Chicago (gynecology)
Henry Schroeder, M.D., St. Louis (cardiac drugs)
Henry Schwartz, M.D., St. Louis (neurologic surgery)

5. JUNE 16: RACINE JUNE 17: ELKHART LAKE JUNE 18: MENOMINEE, MICHIGAN

Speakers: Allan Barnes, M.D., Cleveland (obstetrics)
Richard Capps, M.D., Chicago (liver disease)
James Conway, M.D., Milwaukee (pediatrics)
Joseph Gale, M.D., Madison (chest surgery)

**All provide credit for academy members . . . watch your mail for full announcement!**

# Qualified Physical Therapists in Wisconsin

DURING the 1953 legislative session, the Medical Practice Act was revised to require the registration of physical therapists in the State of Wisconsin. The law describes the qualifications of the registered physical therapist. It was passed in the interest of protecting the patient from treatment by those who are inadequately trained. A registered physical therapist works only upon prescription and under the direction of a qualified physician.

The American Physical Therapy Association is the professional organization of qualified physical therapists in the United States. Members must be graduates of a school or course approved by the Council on Medical Education and Hospitals of the American Medical Association. The Wisconsin Chapter of the American Physical Therapy Association has been prepared to assist physicians and others in the location of qualified physical therapists. Members are listed alphabetically by city in which employed. Active members are those currently employed or available for employment. Inactive members may, upon occasion, be available part time or full time.

## ACTIVE MEMBERS

**Appleton**

Vareka, Joseph J., Morgan School, Appleton

**Beaver Dam**

Berg, Mrs. Myrtle, Lutheran Hospital, Beaver Dam

**Beloit**

Engebretson, Mrs. Janet E., Rockford Memorial Hospital, Rockford, Ill.
Kirk, Civilla, Beloit Municipal Hospital, Beloit

**Eau Claire**

Meagher, Marion A., McDonough Orthopedic School, Eau Claire
Parisi, Peter E., Luther Hospital, Eau Claire
Safford, Charles J., McDonough Orthopedic School, Eau Claire

**Fond du Lac**

Konopisos, Andrew W., Jefferson School, Fond du Lac

**Fort Atkinson**

Wolfgram, Julane, Fort Atkinson Memorial Hospital, Fort Atkinson

**Green Bay**

Hermann, Erna A., Howe Orthopedic School, Green Bay
Miller, Mrs. Libbie B., 1019 Holzer Street, Green Bay
Wilkinson, Gertrude, Howe Orthopedic School, Green Bay

**Janesville**

Smith, Esther J., Pember–Nuzum Clinic and Mercy Hospital, Janesville

**Kenosha**

Fredrickson, Helen L., Orthopedic School, Kenosha
Jaeger, D. LaVonne, Orthopedic School, Kenosha
Prior, Margaret M., Kenosha Hospital, Kenosha

**La Crosse**

Ellsworth, Leora, Emerson School, La Crosse
Robertson, Mrs. Esther, St. Francis Hospital, La Crosse
Strzelczyk, Robert E., La Crosse State College, La Crosse

**Lake Mills**

Latsch, Lois, 307 Fargo Street, Lake Mills

**Madison**

Alter, Audrey J., University Hospitals, Madison
Aumueller, Blanche, University Hospitals, Madison
Bachanz, Lillie M., Bureau for Handicapped Children, State Capitol, Madison
Borwell, Laura B., Madison Orthopedic School, Washington School, Madison
Bridgeland, Barbara J., Wisconsin Neurological Foundation, Madison
Briggs, Dorothy I., Section of Physical Medicine, University of Wisconsin, Madison
Brown, Ellis, St. Mary's Hospital, Madison
Brunsell, Gerald, Wisconsin Neurological Foundation, Madison
Bryce, Margaret E., Section of Physical Medicine, University of Wisconsin, Madison
Burdon, Mrs. Ruth K., University Hospitals, Madison
Butler, Alice I., Veterans Administration Hospital, Madison
Drake, Mrs. Mary, University Hospitals, Madison
Freeman, Gertrude A., Madison Orthopedic School, Washington School, Madison
Harris, Mrs. Ada E., St. Mary's Hospital, Madison
Henry, Fae A., Bureau for Handicapped Children, State Capitol, Madison
Hoffland, Nancy, University Hospitals, Madison
Kampmeier, Lois, University Hospitals, Madison
Kohli, Margaret A., Section of Physical Medicine, University of Wisconsin, Madison
Martin, Patricia, Madison General Hospital, Madison
Mitchell, Lois M., Bureau for Handicapped Children, State Capitol, Madison
Olson, Mrs. Ann D., St. Mary's Hospital, Madison
Shaffer, Kathryn J., Section of Physical Medicine, University of Wisconsin, Madison
Sletten, Mrs. Grace L., Veterans Administration Hospital, Madison
Taslitz, Norman, University Hospitals, Madison
Van Bree, Virginia, University Hospitals, Madison
Wolfe, Russell D., Wisconsin Neurological Foundation, Madison
Wright, Alfaretta, Bureau for Handicapped Children, State Capitol, Madison
Zitzer, Emma, Madison Orthopedic School, Washington School, Madison

**Marshfield**

Gray, Jane M., Marshfield Clinic, Marshfield

**Milwaukee**

Bartlett, Gertrude, Gaenslen School, Milwaukee
Bauerman, Carolyn, Curative Workshop, Milwaukee
Baum, Sister M. Callixta, Sacred Heart Sanitarium, Milwaukee
Bolan, Dolores, St. Joseph's Hospital, Milwaukee
Bolinske, Jane C., 2540 North Maryland Avenue, Milwaukee
Boyum, Kenneth, St. Luke's Hospital, Milwaukee
Burns, Ethel M., Veterans Administration Center, Wood
Cinquemani, Mrs. Grace Aho, Veterans Administration Center, Wood
Clark, Catherine, Milwaukee Hospital, Milwaukee
Crabtree, William R., St. Luke's Hospital, Milwaukee
Dix, Mrs. Joan A., 4921 North Shoreland Avenue, Milwaukee
Dougherty, Mrs. Florence M., Curative Workshop, Milwaukee
Duerr, Richard M., 2673 North Bremen Street, Milwaukee
Erickson, Mary, Milwaukee Hospital, Milwaukee
Frank, Mrs. Katherine O., 832 West Center Street, Milwaukee
Grisa, Arthur M., Veterans Administration Center, Wood
Griswold, Mrs. Christine, Gaenslen School, Milwaukee
Grundemann, Norma M., Girl's Trade & Technical High School, Milwaukee
Hoffman, Jean, 3950 North Farwell Avenue, Milwaukee
Jakubzak, Charlotte C., Curative Workshop, Milwaukee
Jones, Elizabeth M., Gaenslen School, Milwaukee
Koehneke, Anita, Cerebral Palsy Clinic, Milwaukee
Kuhlman, Louise, Curative Workshop, Milwaukee
Loewi, Mrs. Helen, Columbia Hospital, Milwaukee
Lonnborg, Kenneth F., Columbia Hospital, Milwaukee
Mandragos, Dorothy, 1324 West Chambers, Milwaukee
Matthews, Anita, Visiting Nurse Association, Milwaukee
McCrory, Marie A., Veterans Administration Regional Office, Milwaukee
McPeek, Lorena, Curative Workshop, Milwaukee
Miller, Gerald C., 536 West Wisconsin Avenue, Room 408, Milwaukee
Miller, Hattie, Curative Workshop, Milwaukee
Murray, Mary Pat, Veterans Administration Center, Wood
Nagel, Mrs. Rayline C., 1335 North 42nd Street, Milwaukee
Olufs, Robert J., Curative Workshop, Milwaukee
Pfeiffer, Violet R., Veterans Administration Center, Wood
Pfleger, Betty, Milwaukee Hospital, Milwaukee
Phenix, Florence L., Community Welfare Council, Milwaukee
Phillips, Beth J., Section of Physical Medicine, Marquette University, Milwaukee
Poker, Dolores, Veterans Administration Center, Wood
Ritter, Joanna L., Columbia Hospital, Milwaukee
Roehr, Lt. Marilyn, WMSC, 4131 North Ardmore Avenue, Milwaukee
Rohan, Mary, Children's Hospital, Milwaukee
Rohrer, Helen, Gaenslen School, Milwaukee
Sedlet, Mrs. Ethel W., Milwaukee County Hospital, Milwaukee
Slaney, Margaret, Columbia Hospital, Milwaukee
Strom, Barbara Mae, 9326 North Greenvale, Milwaukee
Toms, Helen A., Gaenslen School, Milwaukee
Volle, Margaret J., Visiting Nurse Association, Milwaukee
Wonder, Mrs. Anita C., Curative Workshop, Milwaukee

**Monroe**

Pagel, Eileen, Monroe Clinic and St. Clare Hospital, Monroe
Wheeler, Glen, Monroe Clinic and St. Clare Hospital, Monroe

**Mukwonago**

Hosterman, Mrs. Ethel, Route 2, Box 1, Mukwonago

**Neenah**

Freese, Cecile, Theda Clark Memorial Hospital, Neenah
Longmore, Loren, Theda Clark Memorial Hospital, Neenah

**Oshkosh**

O'Day, Mrs. Cora, Curative Workshop, Oshkosh

**Racine**

Field, Mrs. Bertha H., St. Luke's Memorial Hospital, Racine
Hewstone, LaRita A., Stephen Bull School, Racine
Peterson, Thea, Stephen Bull School, Racine
Sladky, F. Joseph, St. Mary's Hospital, Racine
York, Mrs. Elizabeth, St. Luke's Memorial Hospital, Racine
Zielke, Lyle E., Curative Workshop, Racine

**Sharon**

Hull, Mrs. Geraldine D., Sharon

**Sheboygan**

Hoaglin, Leila, Sheboygan Orthopedic School, Sheboygan

**Stevens Point**

Wiswold, Mrs. Elin I., St. Michaels Hospital, Stevens Point

**Superior**

Moriarity, Margaret C., Holland Orthopedic School, Cooper School, Superior

**Waukesha**

DuBase, Mrs. E. H., Veterans Administration Hospital, Waukesha
Krusell, Lenore M., Waukesha Memorial Hospital, Waukesha

**Wausau**

Gardiner, Dean M., Employers Mutual of Wausau, Wausau
O'Boyle, Mrs. Cornelia, 603 South 5th Avenue, Wausau
Peck, James F., St. Mary's Hospital, Wausau

**West Allis**

Aanrud, Leila R., McKinley School, West Allis
Naggs, Doris, McKinley School, West Allis

**West Bend**

Crawford, Mrs. Bernice, Board of Health, West Bend

OUT OF STATE

Nevue, Lt. Vivian, Army and Navy Hospital, Hot Springs, Arkansas
Wood, Marjorie, Route 1, Box 154, Minot, North Dakota

INACTIVE MEMBERS

Baker, Alice, L., 3443 North Frederick Avenue, Milwaukee
Bender, Mrs. Florence M., 1214 North Drew, Appleton
Bomier, Mrs. Gloria R., 213 Elmwood Court, Neenah
Christen, Alberta E., Waterloo
Clarke, Mrs. Laurine F., 4716 North 45th Street, Milwaukee
DePouw, Loretta M., 222½ Pecor Street, Oconto
Fellers, Mrs. Mary Y., 545 Cliffden Drive, Madison
Gardiner, Mrs. Marion F., 709¼ South 4th Street, Wausau
Hakeem, Mrs. Helen, 530 Orchard Drive, Madison
Higgins, Mrs. Gisella, Route 14, Box 412, Milwaukee
Hoelzl, Margaret, Lake Road, Oconomowoc
Humphreys, Mrs. Jean B., 3622 Cross Street, Madison
Hutchens, Mrs. Velma, Route 2, Box 127AA, Pewaukee
Johnson, Mrs. Bernadine, Box 710, Mt. Horeb
Johnson, Mrs. Sonja K., 1625 John Avenue, Superior
Konopisos, Mrs. Marion, 404 Fourth Street, Fond du Lac
Lipp, Mrs. Enid L., Route 2, Box 223, Fort Atkinson
Lowenstein, Anita K., 5840 North Lydell, Milwaukee
Melin, Ruth, Route 1, Eagle River
Meyers, Marian, 515 North Henry Street, Madison
Miles, Meryl, 251 Langdon Street, Madison
Powers, Mrs. Janet H., University Houses, Apartment 21B, Madison
Reiber, Mrs. Jean E., 10 Embrey Court, Appleton
Rice, Mrs. Virginia K., 2355 North 83rd Street, Wauwatosa
Safford, Mrs. Mary B., 318 Second Avenue, Eau Claire
Schmidley, Margaret H., Central High School, Sheboygan
Schott, Mrs. Stella B., 3424 North Downer Avenue, Milwaukee
Sorbie, Mrs. Mildene B., 2900 52nd Street, Kenosha
Stueck, Mrs. Doris S., 622 North Seventh Street, Manitowoc
Tronca, Mrs. Addis L., 3121 West McKinley Boulevard, Milwaukee
Turner, Mrs. Frances S., 525 West Fulton Street, Waupaca
Walters, Mrs. Jean, 659 Wolfe Street, Box 215, Oregon
Wolfe, Mrs. Peggy H., 1234 Shawano Avenue, Green Bay
Wolff, Anna B., 925 Portland Avenue, Beloit


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# State Board of Health Services and Communicable Disease Rules

MEMBERS OF THE WISCONSIN STATE BOARD OF HEALTH. Seated, left to right: Stephen E. Gavin, M. D., Fond du Lac, president; Carl N. Neupert, M. D., Madison, secretary; Samuel Henke, M. D., Eau Claire, vice-president; Stephen Cahana, M. D., Milwaukee; Carl D. Neidhold, M. D., Appleton. Standing, left to right: W. T. Clark, M. D., Janesville; Forrester Raine, M. D., Milwaukee; Woodruff Smith, M. D., Ladysmith; and E. H. Jorris, M. D., Madison, assistant state health officer.

## AN OVER-ALL VIEW

THE official Board of Health has the responsibility for determining the policies to be followed by the department and for the approval of programs to be developed or in operation. Its seven members are appointed by the governor with the consent of the senate for seven year terms. The Board elects a secretary, who is also the State Health Officer.

Powers of the Board include that of making and enforcing rules and regulations, holding hearings, and issuing orders on subjects under its jurisdiction as established by Statute.

The work of the Board and of the department is supplemented by local boards of health and health officers in all towns, villages, and cities of Wisconsin. The staffs of the eight district health offices keep in touch with the local boards and officers and assist them in any problem that may arise.

The various bureaus, divisions, and units of the department are organized into five main sections. Their activities are described very briefly on the following pages.

## FUNCTIONS AND ACTIVITIES

### Section on General Administration

*Division of Administration,* under the general direction of the State Health Officer, is responsible for organization, direction, and coordination of all of the activities of the State Board of Health. This includes formulation of departmental policies, direction of staff conferences and committee activities, and evaluation and interpretation of departmental policies. The division provides consultation and assistance to other divisions on budget preparation in relation to approved program plans; establishes expenditure controls and provides general supervision over all expenditures; and assists in the preparation and presentation of budget justifications and budget presentations.

*Division of Staff Services* coordinates major operational services to provide for the effective use of personnel, materials, funds, equipment, and business methods. Subdivisions include:

(1) *Division of Personnel* represents the State Board of Health with the Bureau of Personnel on

all matters related to the recruiting, selection, classification, promotion, dismissal, etc., of employees of the department, including the Wisconsin State Sanatorium and Lake Tomahawk State Camp, numbering approximately 415 employees; where requested, studies, analyzes, and makes recommendations on matters related to internal office procedures and techniques and recommends revisions in organization structure or complement; on request, conducts surveys for local full-time health departments to establish appropriate salary schedules and classification systems and submits recommendations calculated to improve the effectiveness of office management and personnel utilization; and assists localities on request in the recruitment of personnel in categories where the market is in short supply.

(2) *Division of Internal Services* includes the central mail and stock rooms; addressographing; the central collection of fees and the issuances of licenses; and duplicating services.

(3) *Division of Fiscal Services* prepares state and federal budgets, payrolls, and audits expenditures for all funds; estimates receipts and expenditures for inclusion in request to the state legislature for funds; maintains records of all appropriations, allotments, and receipts and expenditures of the department and those covering the state tuberculosis sanatorium at Statesan and the Rehabilitation Camp at Lake Tomahawk. It sets up the accounting system, verifies information, and audits the records of the project sponsor under the Hospital Construction program. In addition, it audits the reports of the county tuberculosis sanatoria for payment of state aid.

(4) *Division of Statistical Services* provides tabulating and statistical service to all of the sections and divisions of the State Board of Health. Original reports and documents checked and coded in the various divisions are routed to the statistical service division for machine processing, statistical tabulation and analysis. These tables and analyses are referred to the divisions concerned for final interpretation and are then used in program planning at state and local levels.

*Division of Laboratories*—In 1953 the State Laboratory of Hygiene moved into a new building on the University of Wisconsin campus. Tests made for licensed physicians, veterinarians, health officers, and health commissioners without charge include those to detect the presence of tubercule bacilli, gonococci, meningococci, typhoid and paratyphoid organisms, and ova and cysts of parasites; and those to detect diseases such as rabies, actinomycosis, tularemia, and undulant fever. The laboratory prepares typhoid and paratyphoid vaccines and produces other biologic agents which may be used in the control and prevention of disease.

Other laboratory services are various tests for the recognition of virus diseases; laboratory tests required in special epidemiologic studies; examinations for the recognition of various fungi, parasitic diseases of the intestinal tract, and serologic and cultural tests for the recognition of amoebic dysentery and other diseases where these tests are applicable.

The state branch laboratory at Rhinelander and the various cooperative laboratories were discontinued as of July 1, 1953. Now as city or city-county laboratories they are primarily occupied with tests concerning the sanitation of milk, water, and other foods. They also do tests that are needed in connection with the city health department activities such as restaurant sanitation.

Work previously done in these laboratories is forwarded to Madison. This includes the examination of samples of water submitted from municipalities, state parks, trailer camps, summer resorts, and other public and private agencies.

*Bureau of Vital Statistics*—Vital records of birth, death, marriage, and divorce filed with the Bureau of Vital Statistics fill two essential needs. They provide a legal document for proof of age, identity, relationship, citizenship, etc., so frequently required as a part of our every day life for inheritance, job applications, military service, and old age and social security benefits. These vital records also serve as the basis, after tabulation and analysis, for program planning in public health and the evaluation of programs already under way. They constitute the bookkeeping of public health.

The Division prepares and distributes birth, stillbirth, death, and marriage forms and collects these records from 71 county registers of deeds and 161 city health officers who are designated as "local registrars of vital records," and who, in turn, receive most of the original records from the physician in attendance. It also collects reports on divorces and adoptions from the courts of the state.

It classifies the social and medical information on these records for machine tabulation in conformity with rules governing the International Registration Area. It thus makes available to the individual concerned essential, permanent, legal documentation upon request, for a nominal fee. It supplies to a wide variety of interested people, organizations, and governmental agencies demographic and public health information of indispensable value.

*Division of Dental Education* plans and directs a state-wide program of dental health education and research; conducts controlled studies of the effects of fluoridation of water in the prevention of dental caries; and at present is demonstrating the topical application of fluorides to teeth in certain areas in the state. As of December 1, 1953, there were 95 cities in Wisconsin fluoridating their public water supplies. They include Alma, Amery, Antigo, Appleton, Argyle, Ashland, Athens, Baraboo, Beaver Dam, Belleville, Beloit, Berlin, Black River Falls, Blair, Bloomer, Boscobel, Cambridge, Cedar Grove, Columbus, Cottage Grove, Crestwood, Cuba City, Darlington, De Forest, Delavan, Dodgeville, Eagle River, Eau Claire, Edgar, Edgerton, Elkhorn, Evansville,

*(Continued on page 89)*

# THE MEDICAL FORUM

## VOLUNTARY HEALTH INSURANCE IN WASHINGTON SPOTLIGHT

### HOSPITAL, SURGICAL AND MEDICAL EXPENSE COVERAGE BY STATES

Number of People Protected End of 1952
(000 Omitted)

| State | Hospital | Surgical | Medical |
|---|---|---|---|
| EAST NORTH CENTRAL | | | |
| Wisconsin | 2,496 | 2,308 | 999 |
| Indiana | 2,638 | 2,460 | 877 |
| Illinois | 6,831 | 5,162 | 1,968 |
| Michigan | 5,111 | 4,773 | 2,215 |
| Minnesota | 2,383 | 1,895 | 1,171 |
| Iowa | 1,317 | 1,086 | 589 |
| Total | 20,776 | 17,684 | 7,819 |
| Total United States | 91,667 | 73,161 | 35,797 |

## Wisconsin Has High Population Percentage Covered by Blue Shield Insurance Plans

Chicago, Dec. 8.—Wisconsin is one of a group of ten states which has a high percentage of Blue Shield members. As of September, 1953, 20.50 per cent of Wisconsin residents were carrying Blue Shield protection.

Other states which have from 20 to 40 per cent of their population covered by Blue Shield are Connecticut, Massachusetts, New York, Colorado, Ohio, Indiana, New Jersey, Pennsylvania and New Hampshire and Vermont—the two considered as a unit.

Delaware has the nation's highest percentage of Blue Shield population—63.73 per cent, and both the District of Columbia and Michigan have more than 40 per cent.

Total Blue Shield membership for the United States, Puerto Rico, Hawaii and Canada had reached 27,337,904 last September, as compared to 1,826,719 in 1946. Canada forms a comparatively low percentage of this figure. Only 11.80 per cent of her total population is covered as against 18.54 per cent of the total population of the U. S. and her abovementioned territories.

A total of 75 plans reporting on the percentage distribution of the total income dollar they collect reported that 81.46 per cent is paid for medical and surgical expense, while 11.22 per cent goes for operating expense and 7.32 per cent to reserve funds.

Payments to doctors made by Blue Shield plans in 1952 totaled $208,514,177, which was 79.80 per cent of total subscriber income. $29,983,910 went, during this period, for operating expense. Blue Shield acquired 3,629,363 new members in 1952, the equivalent of 14,385 each working day.

**The charts on this and the following page were borrowed from the Annual Survey of Accident and Health Coverage in the United States for September, 1953, published by the Health Insurance Council.**

Washington, Jan. 19.—Voluntary health insurance plans are coming in for a lot of attention in Washington at present.

President Eisenhower has come out in favor of government "reinsurance" for non-profit plans.

His scheme can be "launched with a capital fund of $25,000,000 provided by the government, to be retired from reinsurance fees."

Rejecting the Truman plan for compulsory health insurance, Eisenhower said "the government need not and should not go into the insurance business to furnish the protection which private and non-profit organization do not provide," but that "voluntary organizations can reach many more people and provide better and broader benefits. They should be encouraged to do so."

### Government Backs Companies

By "reinsurance," he presumably had in mind a system comparable to the one by which the government insures bank depositors against loss. Private health plans would pay a fee for the insurance against major losses, and these fees, supposedly, would in time repay the $25,000,000 set up to start the system.

Said the President, "The best way for most of our people to provide themselves the resources to obtain good medical care is to participate in voluntary health insurance plans. During the last decade, private and non-profit health insurance organizations have made striking progress in offering such plans."

The Federal Trade Commission has launched a nationwide investigation of the advertising claims made by mail-order health insurance companies. According to the Washington Report on the Medical Sciences, much of this advertising is deceptive and objectionable, though trade practice rules were promulgated by FTC in 1950. Chairman Edward F. Howrey has invited the assistance of business-

*(Continued on page 82)*

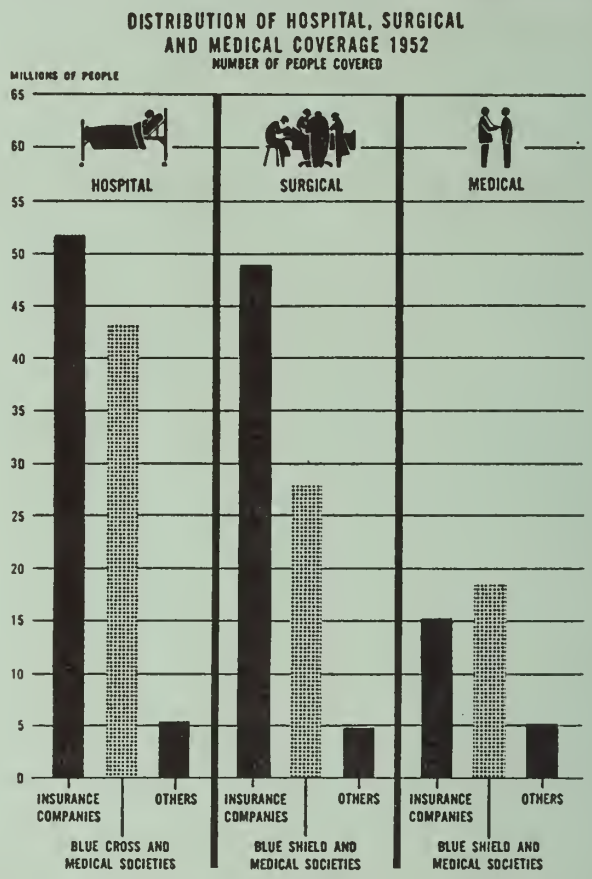
## Major Medical Expense Fast-Growing Addition To Voluntary Coverage

Madison, Jan. 1.—Major medical expense coverage is the newest addition to the voluntary health insurance program, and is designed to help meet the catastrophic costs resulting from prolonged disability.

Broadly speaking, it takes up where the usual forms of hospital, surgical and medical care protection leave off, and covers such costly items as nursing care and the use of special appliances.

Maximum benefits available under this form of protection are from $2,500 to $10,000. It is written with a deductible feature. That is, the insured pays the first hundred or two hundred or even five hundred dollars. It is usually written with a co-insurance feature, which means that above the deductible amount, the insured must pay a certain percentage of the expense. The purpose of this is to encourage the insured to obtain the needed health services as reasonably as possible, thus helping to keep down the costs of protection.

Approximately 689,000 were carrying major medical expense coverage at the end of 1952. An undetermined additional number were protected by plans that provided coverage for prolonged disability or had such high maximum benefits that there was little need for major expense protection.




## Insurance Man Lauds Growth of Health Plans At Washington Hearing

Washington, Dec. 4.—The tremendous growth of voluntary health and accident insurance throughout the nation provides convincing evidence of the ability of insurance companies to furnish satisfactory protection to practically all of the American people, according to E. J. Faulkner, president of the Woodmen Central Life Insurance Co., Lincoln, Neb.

Mr. Faulkner testified before the House Committee on Interstate and Foreign Commerce at a hearing in regard to the country's health needs. He pointed out that the number of companies writing health and accident insurance has increased from 47 to over 800 in the last few decades.

"In no insurance line is there greater heterogeniety of type of insurer or kind of coverage," Faulkner stated. "Accident and health insurance is offered by stock, mutual and fraternal insurers. Their free competition has provided the American citizen with the greatest possible range of choice as to kind of coverage and benefit. Their open, free and keen competition has been the greatest stimulus to successive improvement and broadening of coverage and to continuous experimentation and progress in the public interest. This free competition has been a most effective method by which cost of insurance is controlled."

Faulkner explained that group insurance is designed to provide a floor of protection primarily for employed groups, while individual insurance is the means of reaching the many self-employed who are not reached by group coverage. Individual insurance, he pointed out, is also valuable in supplementing group coverage which, for obvious reasons, cannot be tailored to the particular needs of the individual.

## VOLUNTARY INSURANCE . . .

*(Continued from page 81)*

men, state authorities and the public in the pursuit of the investigation.

With the return of Rep. Charles A. Wolverton, chairman of the House Commerce Committee, from a European fact-finding tour, hearings in regard to voluntary health plans have been resumed. These hearings were recessed in October to give the committee a chance to digest the volume of testimony which had been presented up to that time.

The hearings started again January 6 and are booked through the end of the month. Dates for presentation of their testimony have been assigned to prospective witnesses representing Blue Shield, Blue Cross, health cooperatives, labor plans and medico-economic research organizations.

# Welbourne, Speaking for Society, Lodges Protest Against Maisel Article on Cancer

Madison, Dec. 29.—Dr. R. P. Welbourne, chairman of the State Medical Society's Committee on Cancer, has written a letter of vigorous protest regarding an article entitled "How You Can Double Your Chances Against Cancer," which appeared in the December **Woman's Home Companion.**

This article, written by Albert Q. Maisel, has listed 232 "four-star" hospitals which he alleges offer the most complete diagnostic services and treatment for cancer patients. The only Wisconsin hospitals thus honored are the State of Wisconsin General Hospital and the Milwaukee County Hospital.

### "Disservice To Public"

Dr. Welbourne's letter to all Wisconsin hospital administrators and chiefs of staff states as follows:

"The implications of this article are unwarranted and dangerous, and a positive disservice to the public.

"Albert Maisel's words are certain to thoroughly undermine the faith of the patient in his family physician and his local hospital.

"The arbitrary selection of a limited number of hospitals as those "you can depend upon" for the best cancer care is completely unrealistic. There are many in Wisconsin, alone, which provide wholly adequate and competent care for cancer patients.

### Ridiculous Omissions

"The **Woman's Home Companion** listing is made even more ridiculous by the omission, for example, of the Mayo Clinic, Lahey Clinic and Billings Memorial Hospital, the latter being one of the largest and most modern isotope research and treatment centers in America.

"The American Cancer Society did not approve the article or its contents.

"You should act immediately to bring this article to the attention of your hospital board, medical staff and other local leaders. Protests should be sent at once to the editor, **Woman's Home Companion,** Crowell–Collier Publishing Company, 640 South Fifth Avenue, New York 19, New York.

"Publishers should be made aware of their responsibility for accuracy and objectivity, particularly in articles which affect the lives and health of their readers."

Maisel says that 75,000 deaths this year will go down as caused by cancer, but in reality these people will be killed by "slipshod examinations, unwarranted diagnostic delays and unskillful operations performed by physicians who lack the training and the broad experience to detect cancer early or to operate upon it successfully."

Maisel states that "in city after city, studies by outstanding cancer authorities now reveal that from 10 to over 40 per cent of all doctors fail to examine their patients properly. Although clear signs of advancing cancer are present, they delay diagnosis and fritter away their patients' chances for help."

He also speaks of unnecessary operations, and half-measures used where radical surgery is needed.

He goes on to suggest that if cancer surgery is indicated, the patient should ask his doctor to arrange for his admission to one of his "four-star" hospitals. "There are," he states, "7,000 hospitals in the United States—good, fair and just plain terrible."

### All Teaching Hospitals

His "four-star" hospitals are all teaching hospitals or cancer treatment centers which meet the American College of Surgeons standards for cancer clinics, maintain programs of graduate training in surgery approved by the American College of Surgeons, and are approved by the AMA for the training of interns and for residencies and fellowships.

Maisel admits that adequate treatment is available in other hospitals but his list, he maintains, includes "the best of the best."

As far as is now known, the State Medical Society of Wisconsin is the only major medical group which has organized a strong protest campaign against the article.

Maisel was the winner of the 1951 Lasker Medical Journalism Award. He is the author of two books on military medicine and the writer of many articles on medical subjects. Two recent articles by him in which he criticized the nursing profession unleashed a flood of protesting letters.

# 8.5 Per Cent of Income Absorbed by 1950 Taxes

Washington, Dec. 10.—Federal individual income taxes absorbed nearly 18.5 billion dollars, or about 8.5 per cent of the total income of American families in 1950, the commerce department reports in a special study by its office of business economics of national income distribution in the war and postwar periods.

The study showed that 48.5 million "consumer units" of families and "unattached" individuals received a total before-taxes income of 217 billion dollars in 1950. The national average income was $4,460, with one-third of the units receiving more than this amount. Nearly 6 per cent had incomes of $10,000 and more, 23 per cent were below the $2,000 income figure.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You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

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*Disability Specialists since 1892.*

A Forum Feature

Rehabilitation Stressed

# NEUROLOGICAL FOUNDATION UNIQUE TREATMENT CENTER

Madison, Jan. 3.—Unique among Wisconsin hospitals is the Wisconsin Neurological Foundation, which combines the care of neurological patients with recreation, vocational guidance and training, and job placement.

Care of patients here begins with neurological diagnosis and treatment. Its professional staff includes attending and consulting specialists, all members of their respective specialty boards, not only in the field of neurology, but in medicine, urology, ophthalmology, allergy, orthopedics and surgery. Three part-time dentists comprise the dental service.

The treatment progresses to physical medicine accomplished by trained physicial therapists under the guidance of a physiatrist. As soon as the patient is ready, testing for vocational aptitude takes place and vocational training suited to the patient's limitations is undertaken.

**The Foundation accepts patients with all kinds of chronic neurological disabilities. There are victims of cerebral palsy, multiple sclerosis, muscular dystrophy, Parkinson's disease, polio. There are paraplegics and victims of accidents which have resulted in injury to the nervous system.**

**The Foundation is dedicated to the idea that all these unfortunates have one thing in common—the need to be rehabilited so that they can again become useful, self-supporting members of society.**

Patients can be sent to the Foundation by physician referral from anywhere in Wisconsin. It is hoped that Wisconsin physicians will make increasing use of this center for both private and county patients, for there is no state or local institution with similar facilities for the care and rehabilitation of the severely handicapped. Insurance companies which do not maintain their own rehabilitation centers can send their chronic patients to the Foundation for help.

Located in Madison, the Foundation is housed in the building that used to be known as the East Washington Avenue Hospital and formerly served as Madison's isolation unit. It occupied only the top floor at first, but has now expanded to fill the entire building.

**It has as little of the atmosphere of a hospital as is consistent with good care. Recreation is considered an important therapeutic agent for the social rehabilitation of patients, and an informal, homelike atmosphere prevails. Patients spend their evenings having fun together—watching movies and programs, listening to band concerts, playing games and taking part in songfests. Patients who are not bed-fast eat their meals together instead of in their rooms. They picnic and play games on the hospital lawn when the weather permits.**

Though some occupational therapy takes place at the Foundation, most of the vocational training is accomplished at the Madison Vocational School with patients making the trip from the Foundation and back each day in cabs. The Foundation has a private contract with a cab company for this purpose.

All of the Foundation's services, even including transportation to and from school, are included in the daily hospital rate which ranges from $12.50 to $25. per day, depending on accommodations. There are now two, and will soon be five, private rooms at the top rate. There are ten two-bed rooms and will soon be thirty ward beds.

The full-time staff includes four physical therapists, an occupational therapist, nurses, nurses aids, orderlies, and kitchen and maintenance personnel—thirty-five in all. It also includes a director of vocational rehabilitation and recreation who is a key figure in the program of the Foundation.

**This is Constantine Tziolas, (pronounced Jolas) a former modern language teacher from Beloit, who understands the emotional and physical needs of his students better than most men could, since he himself is a wheelchair case. It is Tziolas who conducts the psychological and aptitude tests to evaluate the patient's dexterity of hand and mind. On the basis of these tests, patients are assigned to classes both at the Foundation and the Madison Vocational School.**

The Foundation is only two and a half years old, and was organized by Dr. Edward P. Roemer, who, as a faculty member of the Neuropsychiatry Department of the University of Wisconsin Medical School, came to recognize the need for combining all the curative and rehabilitative forces available to give neurological pa-

RECREATION ON THE HOSPITAL LAWN

PHYSICAL MEDICINE

# St. Louis Hospitals Distribute Leaflet Outlining Hospital–Press Code of Ethics

St. Louis, Jan. 4.—Barnes Hospital, St. Louis, has been hailed by the press of that city for the installation of a new information service for friends and relatives of patients.

The hospital, however, disclaims credit for any innovation except that they have placed the information regarding patients on the desk of a secretary in the nursing office, and the information is relayed directly from there instead of from the hospital switchboard. The nature of the information released continues to be strictly in accordance with the rules of medical ethics.

A printed guide for information to news services about hospital patients was distributed in October by the Greater St. Louis Area Hospital Council. This guide outlines the following rules:

**For accident cases:**

1. The person's name, address, sex, approximate age, occupation, and name and address of nearest relative or responsible person, may be given out.

**2. The condition of the patient may be reported as good, fair, serious or critical, but no additional description may be given and no prognosis may be made.**

3. A brief statement may be made as to how the accident allegedly occurred, such as by automobile, fall, burn, etc., but no details may be given. It must never be stated or implied that the injury was self-inflicted, or that the patient was intoxicated.

The extent of injuries may be described briefly. In the case of burns, the parts of the body involved may be indicated. Fractures, confirmed by x-ray, may be mentioned by location. If there has been no x-ray, the phrase "possible fracture" must be used. A head injury may be mentioned as such, but skull fracture must not be mentioned unless this has been confirmed by x-ray. Internal injuries may be generally located, as being in the chest, abdomen, etc. In cases of shooting and stabbing, refer to the police for details.

**For non-accident cases:**

1. Information will be released provided permission is given by both patient and attending physician. The hospital should try to obtain permission at time of admission, particularly if the patient is well-known.

**2. Bulletins regarding the patient's condition will be released, if permitted, using the general terms "good, fair, serious or critical."**

3. News of the death of a patient may be released after the family has been notified. If the patient is prominent in the community, the hospital may wish to telephone the press about the death.

**In general:**

1. Patients in the hospital may be photographed only if permission is obtained by the hospital administration from the patient and attending physician.

**2. The hospital may tell the press the name of the attending physician only if his permission has been obtained, and then stipulating that such information is not for publication, but only for purposes of press contact with the physician. The approval for use of the physician's name in the press is a matter between the doctor and the press.**

3. Each hospital shall designate who from its staff is authorized to release information and will give the press, on request, the titles (not names) of such persons. Provision must be made for the full 24–hour schedule. The hospital will not be responsible for any information given by others than those authorized.

The text of the pamphlet concludes with the following statement:

"Recognizing the value of a friendly relationship with the press, hospitals are urged to cooperate, not only in releasing allowable information, but in remembering to contact the press with stories of human interest and news value when they occur in the hospital."

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tients the physical and mental stimulus to "come back."

Dr. Roemer has worked closely with Tziolas and the nursing director, Miss Frances Schuler, who selected an inspired staff. The university, the vocational school and the State Department of Rehabilitation have helped in every possible way.

The Foundation is a private, nonprofit organization which receives all its money from private donations and hospital charges. It is a member of the American and Wisconsin Hospital Associations. Its board of directors includes Dr. Roemer, Dr. William S. Middleton, dean of the University of Wisconsin Medical School; Dr. William A. Werrell, Madison; Leo J. Blied, Madison; Kenneth Parker, Janesville, and John P. Roemer, Milwaukee.

Additional information may be secured by writing to the Foundation's office at 1 West Main Street, Madison.

# UMW Breaks Ground for Last of Ten Hospitals

Washington, Jan. 1.—Construction is now underway on all ten of the new hospitals being built under sponsorship of the United Mine Workers' Welfare and Retirement Fund.

Said Dr. John T. Morrison of the Fund's Washington headquarters, speaking at the groundbreaking ceremonies for number ten at Williamson, W. Va., "They will be centers of service available to the entire community."

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221 State Bank Building
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Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

## Surgical Instruments Presented to Historical Collection by Lundmark

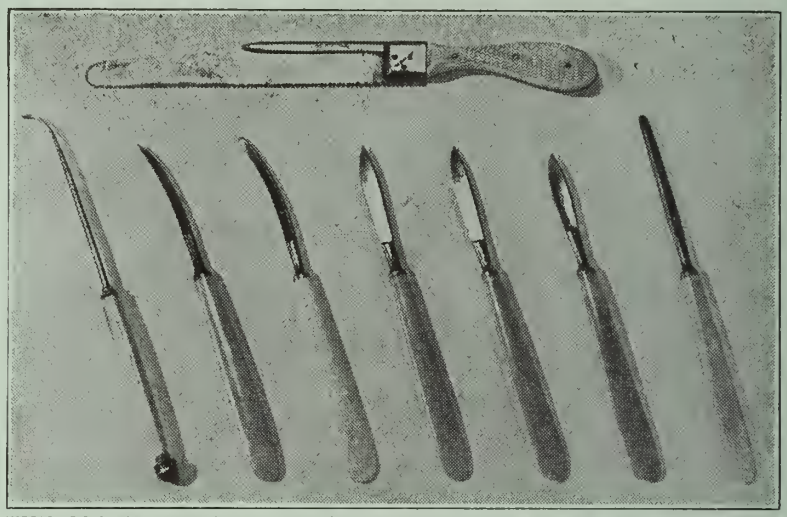
Madison, Jan. 4.—Dr. L. M Lundmark, Ladysmith, has presented to the State Medical Society the set of bone-handled surgical instruments pictured on this page. They are to be offered to the State Historical Society for its collection.

These instruments were presented to Dr. Lundmark by the widow of the late Dr. W. F. O'Connor of Ladysmith, who died in 1946. He, in turn, had received them after the death of Dr. George N. Carnahan who came to Bruce to practice in 1891 and was the first medical practitioner in Rusk County.

Dr. Carnahan was born in Glasgow, Scotland, but came to this country as a boy and graduated with highest honors in his class at the Louisville, Ky., Med ca College in 1878. He interned at Louisville City Hospital, started practice in Louisville, but moved in 1881 to Bently, Ill.

He was brought to Bruce as surgeon for the lumber companies operating there, in 1891, and was the only physician between Barron and Rhinelander for a number of years.

In 1898 he established the Model Drug Store. He was elected postmaster in 1897 and was president of the village in 1902, '03 and '04. He died at the age of 60 in an Eau Claire hospital.



THE OLD SURGICAL INSTRUMENTS pictured above are a bone saw, a suture director and six scalpels. They are made of tempered steel with ornamental ivory handles, and came from the New York firm of W. F. Ford. They were originally the property of Dr. George N. Carnahan of Bruce, the first physician to practice in Rusk County.

## Bad Guessing on Census Affects Social Security

Washington, Dec. 10.—Rep. Carl T. Curtis, Nebraska Republican, claims the Social Security system has been seriously affected by bad guessing about the nation's population growth, according to Insurance Economics Surveys.

He declares that when Congress created the Social Security law in 1934, it had relied on the word of government experts that the U. S. would have a population of 141,000,000 in 1950, with 10,800,000 persons 65 or older. As it has turned out, the population was 151,000,000 in 1950, with 12,200,000 citizens 65 or older.

Curtis is chairman of a house sub-committee studying possible changes in the Social Security system.

## *WISCONSIN PUBLIC HEALTH COUNCIL SEEKS MORE DOCTOR MEMBERSHIPS*

Madison, Jan. 7.—Wisconsin physicians are urged to support the Wisconsin Public Health Council which depends entirely upon membership dues for its funds.

This council is organized for the promotion of public health facilities in Wisconsin, which it works at in various ways.

1. **It encourages the establishment of local health councils or community councils with health panels.**
2. **It seeks to assist and strengthen those already formed.**
3. **It encourages councils and communities to work toward the eventual establishment of city, city-county, county or multi-county full-time health departments.**
4. **It distributes health education materials and acts as a medium of exchange of information between Wisconsin councils.**

It is the hope of the council that membership revenues will eventually expand enough so that a full-time, trained field-worker can be hired. Such a worker could be of great assistance in the establishment of new councils and health services.

Last November, the Wisconsin Public Health Council served with the State Medical Society as co-sponsor of the Wisconsin Health Conference, and arranged for the second day's program. It has instituted an annual award for group achievement in improving the health conditions of a local community, and this award went to the Kenosha Community Health Council at the November meeting.

**Individual membership dues to the Wisconsin Public Health Council are only $2. a year. Physicians are urged to give this support.**

**Checks should be made payable to the council and mailed to 704 East Gorham Street, Madison.**

**The State Medical Society pays an organizational membership each year, as do other professional groups such as the State Dental Society. Members of these groups may also offer support by becoming individual members. Relatively few physicians have become individual members as compared to the number of dentists, nurses and osteopaths who belong.**

Miss Edith Bangham, assistant state leader of home economics extension at the University of Wisconsin, is president of the group, and Dr. Allen Filek of the State Board of Health serves as treasurer. C. H. Crownhart, secretary of the State Medical Society, and Dr. M. W. Stuessy, Brodhead, are on the board of directors.

# HOSPITAL CONSTRUCTION APPROVED FOR WISCONSIN

| Hospital | City | Type | Beds | In Operation |
|---|---|---|---|---|
| (Approved fiscal year 1947-48) | | | | |
| Holy Family | New Richmond | Gen. | 32 | X |
| William Finney Memorial | Clintonville | Gen. | 62 | X |
| Memorial Hospital | Ft. Atkinson | Gen. | 72 | X |
| Vernon Memorial | Viroqua | Gen. | 31 | X |
| Madison General | Madison | Chr. | 128* | X |
| Kempster Hall | Winnebago | Psy. | 248* | X |
| (Approved fiscal year 1948-49) | | | | |
| Memorial Hospital | Tomah | Gen. | 27 | X |
| Memorial Hospital | Menomonie | Gen. | 34* | X |
| Municipal | Platteville | Gen. | 30 | X |
| St. Joseph's | Dodgeville | Gen. | 43* | X |
| Ladd Memorial | Osceola | Gen. | 10* | X |
| Memorial Hospital | Burlington | Gen. | 38* | X |
| Approved fiscal year 1949-50) | | | | |
| Memorial Hospital | Darlington | Gen. | 36 | X |
| Memorial Hospital | Algoma | Gen. | 30 | X |
| St. Benedict | Durand | Gen. | 44 | X |
| Municipal | Ripon | Gen. | 38* | X |
| St. Joseph's | Rice Lake | Gen. | 54* | X |
| Memorial Hospital | Waukesha | Gen. | 32* | X |
| Luther | Eau Claire | C&P | 51* | X |
| State Laboratory | Madison | Lab. | ------- | X |
| Victory Memorial | Stanley | Gen. | 9* | X |
| Memorial Hospital | Berlin | Gen. | 38* | X |
| St. Luke's | Milwaukee | Gen. | 194 | X |
| Memorial Hospital | Sheboygan | C&P | 63* | X |
| Columbia | Milwaukee | Psy. | 21* | X |
| (Approved fiscal year 1950-51) | | | | |
| Memorial Hospital | Boscobel | Gen. | 31 | X |
| St. Joseph's | Hillsboro | Gen. | 30 | X |
| Community | New London | Gen. | 18* | X |
| (Approved fiscal year 1951-52) | | | | |
| Vernon Memorial | Viroqua | Gen. | 17* | X |
| Richland | Richland Center | Gen. | 44* | ------- |
| St. Mary's | Rhinelander | Gen. | 76* | ------- |
| Lutheran Memorial | Oconomowoc | Gen. | 66 | |
| Lutheran | La Crosse | C&P | 64* | ------- |
| (Approved fiscal year 1952-53) | | | | |
| Hayward Memorial | Hayward | Gen. | 46** | ------- |
| Neillsville | Neillsville | Gen. | 45 | ------- |
| Langlade County | Antigo | Gen. | 52* | ------- |
| Reedsburg Municipal | Reedsburg | Gen. | 26* | ------- |
| Lakeland Memorial | Woodruff | Gen. | 18 | ------- |
| Memorial Hospital | Lancaster | Gen. | 36 | ------- |
| (Approved fiscal year 1953-54) | | | | |
| Riverside Memorial | Waupaca | Gen. | 36** | ------- |
| Adams Community | Adams | Gen. | 15 | ------- |
| Memorial Hospital | St. Croix Falls | Gen. | 20 | ------- |
| Vernon Memorial | Viroqua | Mat. | 10* | ------- |
| Divine Savior | Portage | Gen. | 35 | ------- |

* After the number of beds indicates an addition to an existing facility.
**Means remodeling of an existing facility. The above construction has been approved by the State Board of Health. Most of those hospitals still under construction were financed on the basis of 45% federal government funds and the remainder local funds. Hospitals approved prior to January, 1950 received about one third federal funds.

**Estimated total cost of this construction is approximately $33,000,000 with local sponsors providing approximately $21,000,000. Bed capacity thus provided is approximately 2,050.**

## Portland Doctor Mails Newsletters With Bills

Portland, Ore., Jan. 10.—Dr. Bernard P. Harpole, young Portland physician, has hit upon a monthly newsletter as a means of sugar-coating the pill medical bills are to some patients.

Dr. Harpole's first letter began: "The thought has occurred to me that opening a stack of bills around the first of the month can be pretty unpleasant. . . . This, then, is my attempt to make one of the most unpleasant parts of medical practice a little less so. My plan is to enclose a letter like this with each bill. In these letters I'll try to keep you informed about medical matters I think you'll be interested in."

The idea clicked at once. That was more than a year ago. The doctor now sends out about 400 newsletters each month—not only to patients who owe him money, but to many who don't.

His subject matter has run all the way from immunization to parking to diet to nose drops to politics. He is practicing public relations at an all-important level—the doctor's office.

## Put Your County Society on the Television Map!

**Your county society can offer a series of educational and entertaining TV shows to the viewers in your area, and get public relations credit for it.**

**The AMA has a series of films cleared for television use, and available for local showings only. None will be televised over national chains. You can obtain them on loan from the AMA, and they can be shown locally on public service time, sponsored by your society.**

**Many new stations are eager to line up this type of program.**

**Especially recommended for this purpose are "Operation Herbert," 27 minutes; "A Citizen Participates," 28 minutes; "Your Doctor," 15 minutes; and "What to Do," a series of 5-minute films. For more information on these films and how to obtain them, write to the State Medical Society, Box 1109, Madison.**

## Cohen Becomes Social Security Research Head

Washington, Dec. 21.—John W. Tramberg, former director of the Wisconsin Department of Public Welfare, is soon to have Wilbur J. Cohen as research director of his agency.

Cohen, who has long been with Social Security, is presently one of Tramberg's technical advisers. Cohen is accepting the new post in spite of the fact that it means a reduction in pay and grade, according to the Washington Report on the Medical Sciences. As advisor to the Wage Stabilization Board last year, he worked effectively and cordially with Blue Shield and Blue Cross.

Cohen succeeds I. S. Falk, one of the framers of Social Security, who has held the research post since 1940. Falk, one of the main targets of criticism left over from the Oscar Ewing era, has declined a new job in the Bureau of Old Age and Survivors' Insurance. He has been borrowed by the World Bank for a special six-months mission to Malaya and Singapore, and upon his return he will not go back to HEW.

# AMA PR Meeting Features Medical And Lay Authorities as Speakers

St. Louis, Dec. 10.—More than 350 physicians and medical society lay personnel attended the St. Louis public relations conference of the AMA, where policies, problems and techniques in the field of medical public relations were discussed from all angles.

Dr. Walter B. Martin, Norfolk, Va., president-elect of the AMA, said in his key-note address that "health is no longer entirely an individual matter between a physician and a patient." Problems that arise, he stated, need careful joint exploration for the purpose of coordinating all health activities for the total benefit of the public.

"I like to think of public relations not as a means of putting ourselves in a better light before the public," Dr. Martin said, "but as a way by which we can learn better how to serve the public and improve the quantity and quality of medical care and its availability."

### Understanding Necessary

Dr. Leo H. Bartemeier, Detroit, chairman of the AMA Committee on Mental Health observed that many adult patients expect the same understanding attitude from their physicians, the same omniscience and the same omnipotence they believed, when they were children, that their mothers possessed. Repeated failure to understand patients in matters which are of a serious nature to them tends to turn them against medicine.

Howard W. Bennet, public relations expert with the General Electric Company, told the conference that "the American system is different from any other system in the world the same as American medical societies are different from any other medical societies around the globe." To protect this system, he declared that all of us should be on the lookout for proposed changes that might remove an essential part of it.

Roger Fleming, secretary-treasurer of the American Farm Bureau Federation, Washington, D. C., remarked that while medicine is criticized for having an alleged negative attitude, it is well to remember that seven out of the ten commandments start out "thou shalt not."

Rollen Waterson, Oakland, Cal., executive secretary of the Alameda–Contra Costa Medical Association told the group "If we are to have good public relations with people, we have to back up what we say, be what we pretend to be, and produce a uniformly good product."

Describing the work of a hospital tissue committee, Dr. Henry V. Weinert, Passaic, N. J. declared that "properly encouraged, physicians will permit self-examination and correction, which is excellent prophylactic therapy for future adverse publicity and another step to good public relations."

A summary of the conference speeches appeared in the last AMA Journal, but was not published in pamphlet form as has been the custom in recent years.

# Hospital Association Reaffirms Insistence on High Quality Care

San Francisco, Dec. 1.—The American Hospital Association reaffirmed its intention of maintaining high standards of hospital care within its member hospitals at its recent annual meeting.

It passed a resolution stating as follows:

Resolved, that the American Hospital Association reaffirms the Institutional membership requirements which restrict the hospital medical staff to licensed doctors of medicine of good repute who are graduates of medical colleges recognized by the American Hospital Association,

And be it further resolved, that state hospital associations be encouraged to maintain standards of hospital care by requiring also that their member institutions restrict the hospital medical staff to licensed doctors of medicine of good repute who are graduates of recognized medical colleges.

# DEFENSE DEPARTMENT AMENDS DIRECTIVE

Washington, Dec. 20.—The latest Department of Defense directive clarifying the new doctor draft law has been amended to correct an inequity.

According to the original directive, "special registrants not yet commissioned will be commissioned according to their years of experience." This might have been construed to mean that certain physicians would find it to their advantage to delay acceptance of a commission until additional months of experience were accumulated. It was so interpreted in an article in the November Medical Forum.

This sentence has now been clarified as follows:

"Any physician, dentist or veterinarian who is a member of a reserve component will, upon being ordered to active duty, be reappointed or promoted to such higher grade as he is entitled to, based upon his length of professional experience computed to the time of entry on active duty."

In other words, time which elapses between the time a special registrant is commissioned and the time he is called to active duty will be credited in determining his rank.

# Medical Education Foundation Needs Wisconsin Contributions

**Wisconsin physicians are urged to make contributions to the American Medical Education Foundation.**

**This Foundation raises money to help pay the deficits incurred each year by the nation's 79 medical schools.**

**Dr. A. H. Heidner, West Bend, chairman of the fund-raising campaign for Wisconsin, explains that contributions may be earmarked for any school you desire, but only if your contribution goes through the Foundation can the medical profession be given credit for its total effort to help itself.**

**All contributions are tax-exempt. Checks should be made out to the Foundation and mailed to 535 North Dearborn Street, Chicago 10.**

Fond du Lac, Fort Atkinson, Galesville, Gillett, Hartford, Hayward, Horicon, Janesville, Lake Geneva, Lodi, Madison, Marinette, Marshfield, Mayville, Mazomanie, Menasha, Menomonee Falls, Middleton, Milton, Milwaukee, Mineral Point, Mosinee, Mount Horeb, Mukwonago, Neenah, Neopit, New Glarus, New Holstein, Oregon, Orfordville, Osceola, Oshkosh, Phillips, Platteville, Portage, Port Washington, Poynette, Prairie du Sac, Racine, Reedsburg, Rhinelander, Rice Lake, Richland Center, Ripon, Sheboygan, Shell Lake, Soldiers Grove, South Milwaukee, Sparta, Spooner, Spring Green, Stoughton, Sun Prairie, Tomahawk, Trempealeau, Two Rivers, Watertown, Waunakee, Waupun, Wausau, West Bend, Whitehall, and Wisconsin Rapids.

*Division of Health Education* provides special assistance in health education activities for all sections and the district offices; promotes and develops health education activities in local health departments and in official and non-official agencies interested in health.

In cooperation with various other divisions, folders, leaflets, and pamphlets are published by the department to meet specific health education needs. Copies are available without charge to Wisconsin residents. A quarterly bulletin, "Health," is sent to 19,000 persons and organizations with some special interest in public health in Wisconsin.

This division also maintains one of the most active film libraries in the country and makes its visual aids available without charge to all residents of our state. In addition to sound motion pictures in color, the library includes sound and silent filmstrips and transcriptions for radio broadcasting. Rural demonstrations of health visual aids are conducted in selected counties by the district health offices. They loan projectors and health films to rural schools and adult groups in a round-robin circuit.

*Division of Hospital and Related Services.*

(A) HOSPITAL SURVEYS AND CONSTRUCTION inventories existing hospitals (general and allied, chronic disease, mental, tuberculosis sanatoria, public health centers, and related facilities), including public, nonprofit, and proprietary hospitals; surveys the need of such public and other non-profit hospitals as will afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all of the people of the state. The state act has set up an advisory hospital council to assist and consult in the development of the state plan.

The plan establishes a list of priorities for 76 areas of the state for the approval of general hospital projects. The order of priority is based primarily on the relative need for hospital facilities, although special consideration is given to rural areas and areas with low financial resources.

Applications are received at the beginning of each fiscal year. Projects are approved shortly thereafter within the limitation of federal funds available. Forty-five projects have already received initial or final approval during the seven years of the program. Thirty-eight are for 1,575 general hospital beds. The remaining seven are for other categories: chronic disease, one; psychiatric, two; combination chronic and psychiatric, three; and a new state laboratory of hygiene building. The 45 projects have absorbed all of the federal aid available during the seven fiscal years of the program.

Wisconsin's share of the annual federal allotment amounts to approximately $1,325,000. The state plan provides that 55 per cent of the construction costs be borne by the applicant.

(B) HOSPITAL STANDARDS. Standards for the maintenance and operation of hospitals are developed with the assistance of an advisory committee. Approval is granted to hospitals maintaining such standards. Maternity hospitals are licensed under a separate statute under which rules and regulations are established and adherence required for licensure.

(C) NURSING HOMES. The division is responsible for the licensure, inspection, and regulation of nursing homes, including boarding and convalescent homes for the aged, infirm or chronically ill, proprietary, nongovernmental or governmental, except county institutions subject to the supervision of the State Department of Public Welfare.

An advisory committee of persons with recognized ability in the fields of hospital administration, nursing home operation, medicine, nursing, and social services and persons with broad civic interests representing the general public advises and consults in the establishment and review of minimum standards and rules and regulations for such homes.

*Division of Barbering* enforces state laws governing barbering and examines and licenses all persons engaged in barbering.

*Division of Funeral Directing and Embalming* enforces state laws governing funeral directors, embalmers, apprentices, and funeral establishments; registers apprentices and supervises the training program; examines and licenses all funeral directors and embalmers; licenses funeral establishments.

*Division of Cosmetology* enforces the state law governing cosmetology by inspection and investigation; examines and licenses all cosmetologists; registers apprentices in beauty salons and students in schools of cosmetology; licenses beauty and electrolysis salons and schools of cosmetology.

### Section on Environmental Sanitation

This section exercises general supervision and guidance over public health engineering activities in the state.

*Bureau of Sanitary Engineering* has specific functions described under the following headings:

PUBLIC WATER WORKS.—Maintains general supervision over the installation and operation of public water supplies, including the approval of plans and specifications for construction; interstate carrier water supply certification in cooperation with the United States Public Health Service; promotes new systems.

PUBLIC SEWAGE WORKS.—Supervises the installation and operation of public sewage systems, including the approval of plans and specifications for construction; and promotes new systems.

MILK SANITATION.—Promotes adoption of uniform ordinances and codes and enforcement thereof, cooperates with the Department of Agriculture in supervising and certifying milk products for interstate or intrastate shipment, and recommends certification of milk used on common carriers.

GENERAL SANITATION.—Supervises sanitary control over swimming pools and beaches, camps (recreational, industrial, trailer), garbage and refuse disposal, atmospheric pollution control, and other miscellaneous sanitation activities; certifies industrial camps.

*Division of Plumbing* licenses plumbers; enforces the state plumbing code; promotes adequate plumbing and sanitation in rural and urban areas, including the approval of plans for comfort stations and lake and stream plots.

*Division of Well Drilling* registers well drillers and pump installers; administers the pure drinking water law, the state well construction code, and the pump installation code; issues permits on high capacity wells; and supervises ground water developments.

*Division of Rendering and Slaughtering* inspects and licenses; approves sites and plans for new construction; promotes improved operation of plants.

*Division of Water Pollution Control* conducts pollution surveys; studies trade wastes and other pollution abatement measures, conducts routine and special stream surveys, conducts cooperative studies with industries, supervises aquatic nuisance control procedures, and renders other services for the State Committee on Water Pollution.

## Section on Maternal and Child Health

*Bureau of Maternal and Child Health* directs its activities to programs and services that will reduce maternal and infant deaths and prevent physical and emotional illness. It studies and interprets statistical information from birth and death certificates in order to keep professional and lay persons throughout Wisconsin informed on special needs. Assistance is made available to local communities in planning and carrying on health activities for expectant mothers and children and in providing on-the-job training of staff and professional groups. Literature on prenatal, infant, and child care, including a prenatal letter series, is prepared and provided for educational purposes.

OBSTETRIC AND PEDIATRIC EDUCATION is carried on with the State Medical Society through joint projects such as lectures, courses, and research undertaken through special studies on maternal, fetal, and infant mortality.

NURSING CONSULTANTS work through the district offices and directly with hospitals and public health and social agencies to help communities establish more adequate services for mothers and children. They assist in interpreting community needs, in carrying on staff education, in demonstrating technical phases of nursing care, and in organizing parent education projects. Effort is made to coordinate the work of the public health and hospital nurses and to encourage the medical profession to make use of the public health nurse for educational home visits to patients needing special help. Incubators are placed in strategic hospitals to assist in providing more adequate care for the immature and newborn infant.

SCHOOL HEALTH. Consultant service is provided school administrators, supervisors, classroom teachers, public health personnel, and teacher education institutions by the school health consultant. The Wisconsin Cooperative School Health Plan is encouraged in all school systems in the state. This emphasizes health protection and health instruction of each school child through healthful living, health services, and plan of health instruction.

The Wisconsin State School Health Council, composed of 47 members from 36 groups, serves as an advisory and recommending body to the Wisconsin Cooperative School Health Plan. The Medical Society has two representatives on this Council. Also, through its Division on School Health, the Medical Society offers advice on new plans and projects for improving physical and mental health.

Emphasis is placed on routine health supervision of preschool and school children by the family physician. There is also increased emphasis on the health examination of school employees. Section 40.16 (14) of the Wisconsin Statutes enables school boards to require and pay for periodic health examination, including chest x-rays of all school employees and of school children. Coordinated projects emphasizing this aspect of the school health program include the 1952 State Conference on Physicians and Schools, a survey questionnaire to all school administrators in 1953, and planned regional meetings of physicians and administrators to be held in 1954 and 1955. These are all joint projects of the Wisconsin School Health Council and the School Health Division of the Medical Society.

*Division of Child Guidance* helps to organize educational and clinical programs in preventive aspects of mental health; provides consultation and demonstration service to community guidance centers; cooperates in a training center for specialists in this field; promotes and encourages local projects in community mental health education; acts in advisory capacity on mental health matters to organizations and agencies; participates in postgraduate medical education in preventive psychiatry and in-service training programs for public health workers, teachers, and social workers; carries out programs of lay education through all media; provides bulletins and films on childhood problems; is affiliated with the University of Wisconsin in providing facilities for teaching psychologic aspects of child care.

### Local Preventive Mental Health Service

Ashland County Child Guidance Service, Vaughan Library Building, Ashland: Lawrence R. Gowan, M.D., Consulting Director.

Brown County Child Guidance Center, 319 East Walnut Street, Green Bay: Elizabeth D. Kane, M.D., Director.

Dane County Child Guidance Center, 427 State Street, Madison 3: Leland K. Reeck, M.D., Director.

Dodge County Child Guidance Center, Court House, Juneau: George F. Meisinger, M.D., Director.

Douglas County Child Guidance Center, 511 City Hall, Superior: Lawrence R. Gowan, M.D., Director.

Fond du Lac County Child Guidance Clinic, Court House, Fond du Lac: Stuart C. Runkle, M.D., Director.

Green County Child Guidance Center, Court House, Monroe: Hertha Tarrasch, M.D., Director.

Jefferson County Child Guidance Clinic, Court House, Jefferson: Hertha Tarrasch, M.D., Director.

Kenosha County Guidance Clinic, 5619 6th Avenue, Kenosha: Harold T. Schroeder, M.D., Director.

La Crosse County Child Guidance Clinic, 419–421 Newburg Building, La Crosse: C. F. Midelfort, M.D., Director.

Manitowoc County Guidance Center, 1010 South 7th Street, Manitowoc: Keith M. Keane, M.D., Director.

Milwaukee County Guidance Clinic, 515 Public Safety Building, Milwaukee 3: Sara G. Geiger, M.D., Director.

Racine Community Guidance Clinic, 9 City Hall, Racine: Harold T. Schroeder, M.D., Director.

Rock County Child Guidance Clinic, 26 South Bluff Street, Janesville: Hertha Tarrasch, M.D., Director.

Sheboygan Guidance Center, 211 Security National Bank Building, Sheboygan: Keith M. Keane, M.D., Director.

Walworth County Child Guidance Center, 209 West Walworth Avenue, Elkhorn: Joseph Rheingold, M.D., Director.

Walworth County Schools Psychiatric Services, Park Building, Elkhorn: Hertha Tarrasch, M.D., Director.

Waukesha County Child Guidance Clinic, 313 Court House, Waukesha: Ervin Teplin, M.D., Director.

Wisconsin University Hospitals, Central Child Guidance Service, Madison.

*Division of Nutrition* is responsible for developing and carrying on a program to assist people of all ages to choose the foods needed for good health.

Staff nutritionists, who also are qualified, experienced dietitians, work with professional personnel in health, welfare, and educational agencies. They assist administrators and medical staffs of small hospitals and nursing homes in improving dietary department procedures, planning adequate facilities, and training personnel.

The nutritionists assist directors of children's institutions and camps in improving food standards; work with school administrators to operate good school lunch programs and to use the programs to improve food habits; provide public health nurses and teachers with basic nutrition facts and guide them in planning nutrition education activities.

Through educational pamphlets, newspaper releases, radio talks, and community group meetings the public is further provided with up-to-date nutrition information.

### Section on Local Health Administration

This section is concerned with planning, organizing, and supervising the activities of the district offices, county, city-county, and multiple county health departments, and other bureaus and divisions in the section.

*Division of Local Health Administration* plans for, and assists in, the development of full-time city-county, county, and multiple county health departments throughout the state. It advises and assists local health officials in the 1,800 health districts through the eight district health offices. Help is given to local health departments in evaluating and directing their programs; making surveys and studies of local needs; securing financial aid; preparing budgets for local health departments; and planning and promoting a continuous program of professional education for public health personnel.

Eight District Health Offices. The state has been divided into eight districts by the State Board of Health, with a full-time medical officer in charge of public health activities in each district. An advisory public health nurse, sanitary engineer, and secretary make up the staff in each office. A few of the districts have additional public health personnel, such as a nutritionist, dental hygienist, or health educator. Many of the districts have been assigned a hotel and restaurant inspector and a stream pollution engineer. The personnel of these offices is available upon request for consultation on any questions pertaining to public health, control of communicable disease, public health nursing, or sanitation.

*Bureau of Public Health Nursing* gives consultant services to public health nurses and to official and voluntary health organizations regarding public health nursing policies and administration. It studies and analyzes reports of local public health nurses and prepares manuals, guides, records, and report forms to aid the local nursing services in guidance of local programs. A register of public health nurses is maintained, and credentials of qualified applicants are supplied to any employing body. It plans, encourages, and participates in continuous staff education programs for state, district, and local public health nursing staffs. It assigns and supervises rural field experiences for public health nursing students.

*Division of Industrial Hygiene* makes studies to determine whether workers in all types of indus-

tries are exposed to poisonous dusts, fumes, vapors, or gases. If harmful exposures are found, recommendations for control are made to the management. The division provides nursing consultation and assistance in planning a part-time or full-time industrial nursing service and promotes medical programs that include physical examinations (pre-employment and periodic re-examinations). Annual clinics for practicing physicians are organized on industrial health and safety problems. Research is conducted to develop new equipment and methods to evaluate the potential health hazards associated with the use of new industrial chemicals. This division works closely with the State Industrial Commission and other state departments to carry out an effective program.

*Division of Hotels and Restaurants* inspects and recommends proper sanitary conditions in hotels, restaurants, and other licensed places that serve food to assure the public of good wholesome food properly prepared and served, as well as a safe and sanitary environment. Hotels, restaurants, tourist rooms, tourist cottages, tourist cabins, roadside stands, taverns, drug stores or any other permanent place that serves food or furnishes lodging to the general public are licensed by this division. Also licensed are all eating places at fairs, carnivals, or similar gatherings to assure the public that a standard of sanitation and safety is maintained.

This division works with the Plumbing Division, Industrial Commission, local health departments, and other agencies to see that all lodging places or places that feed the general public are properly licensed and inspected for safety and sanitation from year to year. This inspectional work is supplemented by food handling schools conducted throughout the state to cover all phases of proper food handling practices.

## Section on Preventable Diseases

With the progress of medical science, many deadly diseases have been reclassified as preventable. This section is engaged in the vital task of keeping public health practices up to date. The basis for this activity is the systematic collection and analysis of morbidity and mortality data, aimed at directing not only administrative practices toward a reduction in the causes of sickness and death but also a retardation in the progressiveness of incurable disease which should be detected as early as possible.

*Bureau of Communicable Diseases* administers, promotes, and encourages local projects for the prevention of communicable diseases through the agency of the local health officers.

*Division of Tuberculosis Control* plans and assists in carrying out a comprehensive program aimed at the eradication of tuberculosis. To achieve this, it operates mobile x-ray units for the systematic mass survey of entire counties, and performs specific duties relative to the finding, treating, and rehabilitating of tuberculous persons. A central register of tuberculosis cases to aid local health agencies in the follow-up of all reported and suspected cases of tuberculosis is maintained.

This division has under its general supervision the activities of the Wisconsin State Sanatorium and Lake Tomahawk State Camp. Wisconsin State Sanatorium is a 241 bed institution which is operated primarily for the treatment of patients with incipient tuberculosis. Lake Tomahawk State Camp provides for the rehabilitation of male and female tuberculous patients.

*Division of Heart Disease Control* is developing a program of professional and lay education, community service, and research to reduce morbidity and mortality from heart diseases, the leading cause of death.

*Division of Venereal Disease Control* maintains information on sources and incidence of venereal diseases; seeks to find and bring under treatment all persons who have venereal disease in a communicable stage; provides follow-up of contacts for private physicians.

*Division of Cancer Control* encourages early diagnosis, adequate treatment, and follow-up of cancer patients; prepares statistical studies of case reports as a part of this program; cooperates with state and local medical and dental societies, state universities, the Wisconsin Division of the American Cancer Society, and other interested agencies and persons in conducting postgraduate, medical and lay education programs.

### Reportable Communicable Diseases

*Summary of Rules*

| Disease | Isolation Patient | Restriction Contact | Placard |
|---|---|---|---|
| Actinomycosis | None if under medical care | None | None |
| Amebic dysentery | Food handling restricted | Food handling restricted | None |
| Anthrax | Until lesions healed | None | None |
| Bacillary dysentery | Food handling restricted | Food handling restricted | None |
| Brucellosis | None | None | None |
| Chickenpox | 7 days from onset | None | None |
| Cholera | 14 days or negative stools | 5 days or negative stools; see also H 49.10 | Yes |
| Diarrhea, newborn | Special; see rule | See rule | None |
| Diphtheria | 10 days and negative cultures | 5 days and negative cultures; see also H 49.10 | Yes |
| Encephalitis | 7 days from onset | None | None |
| German measles | 7 days from onset | None | None |
| Hemorrhagic jaundice | None | None | None |
| Hepatitis, infectious | 7 days from onset | None | None |

| Disease | Isolation Patient | Restriction Contact | Placard |
|---|---|---|---|
| Histoplasmosis | None | None | None |
| Leprosy | Yes; see rule | None | None |
| Malaria | Until blood negative for parasites | None | None |
| Measles | 7 days from start rash | Susceptibles: 7 days beginning 2nd week exposure | None |
| Meningitis, meningococcal | See rule | None | None |
| Mumps | Minimum 7 days | None | None |
| Ophthalmia neonatorum | None if under medical care | None | None |
| Paratyphoid and carrier | 7 days after symptoms and 2 negative cultures | Food handling restricted; see also H 49.10 | None |
| Plague | Minimum 14 days | In pneumonic form, 7 days from last exposure; see also H 49.10 | Yes |
| Poliomyelitis | At least 7 days from onset | Household contacts under 16–18 one week; see rule | None |
| Psittacosis | During acute stage of disease | None | None |
| Rabies | None if under medical care | None | None |
| Rheumatic fever | None | None | None |
| Salmonellosis (other than typhoid and paratyphoid) | None | Food handling restricted; see also H 49.10 | None |
| Smallpox | Until disappearance of crusts and scabs | 18 days or successful vaccination within 3 days of exposure; see also H 49.10 | Yes |
| Streptococcal Infections, Respiratory (including Scarlet Fever, Streptococcal Sore Throat, and "Septic Sore Throat") | Not less than 7 days; see rule | None except by rule of local board of health; see also H 49.10 | None |
| Tetanus | None | None | None |
| Tinea capitas | Limited; see rule | None | None |
| Trachoma | None if under medical care | None | None |
| Trichinosis | None | None | None |
| Tuberculosis | Special; see rule | None | None |
| Tularemia | None | None | None |
| Typhoid fever and carrier | 7 days after symptoms and 2 negative cultures | Food handling restricted; see also H 49.10 | None |
| Typhus | During febrile period; delousing | Delousing | None |
| Venereal disease | None if under medical care | Examination | None |
| Whooping cough | 28 days from onset | Limited: see rule | None |
| Yellow fever | 7 days | None | None |

## Part I. Rules and Regulations of the State Board of Health in the Control of Communicable Diseases

### H 45.01 Reporting

All communicable diseases which are designated as reportable under these rules shall be reported by all physicians and other persons having knowledge of such diseases to the local health officer and by the local health officer to the state board of health unless otherwise specifically provided.

### H 45.02 Definitions

(1) *Case.* A person whose body has been invaded by an infectious agent, with the result that symptoms have occurred.

(2) *Carrier.* A person who harbors a specific infectious agent without demonstrating symptoms or signs of the disease.

(3) *Contact.* A person who has been intimately in contact with an infected person such as the daily contact of a patient with his parents, his brothers and sisters, other occupants of the home, and the like.

(4) *Isolation.* By isolation is meant the separation of cases or carriers from other persons in such places and under such conditions as will prevent the direct or indirect conveyance of the infectious agent to susceptible persons.

(5) *Quarantine.* By quarantine is meant the limitation of freedom of movement or isolation of contacts who have been exposed to a communicable disease, for a period of time equal to the longest usual incubation period of the disease to which they have been exposed.

(6) *Disinfection.* Disinfection denotes the destruction of infectious agents by chemical or physical means. In general, two types of disinfection are employed:

(a) *Concurrent.* Disinfection carried on continuously during the illness of the patient, such as destruction by use of chemical or physical means of discharges of the patient and cleaning of any infectious material which has come into contact with the patient or may have been soiled by him.

(b) *Terminal.* The elimination of the infectious agent from personal clothing, belongings, and the immediate physical environment of the patient.

### H 45.03 Enforcement

It shall be the duty of the health officer of every local board of health in this state to enforce the rules of the state board of health covering communicable diseases or a suspected case of communicable disease whenever a case is reported or becomes known to him within his jurisdiction.

### H 45.04 Communicable Diseases

The diseases listed in rules H 45.05 through 47.12 are declared to be communicable diseases and the control measures for each specific disease shall be as herein provided. All reasonably suspected cases of communicable diseases shall be regarded as actual cases until proved otherwise and all rules and regulations applicable to actual cases shall be applied to them.

**H 45.05 Actinomycosis**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation: None, provided the patient is under medical supervision.
  (c) Reporting required

(2) Contacts—No restrictions

(3) Environment
  (a) Concurrent disinfection of discharges from lesions and articles soiled therewith.
  (b) Terminal disinfection by thorough cleaning

**H 45.06 Amebic Dysentery**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation: None. No person having amebic dysentery, or who is a carrier of amebic dysentery, shall handle, prepare, or serve food for public consumption until completion of treatment and three negative stool tests, taken not less than one day apart, are obtained.
  (c) Reporting—All cases and carriers of amebic dysentery shall be reported to the local health officer. The occupation of such persons shall be forwarded in the report.

(2) Contacts—Restrictions: Quarantine—None. Contacts within the home are prohibited from handling or preparing food for public consumption until two negative stool tests, on consecutive days, are obtained.

(3) Environment
  (a) Where the premises occupied by the patient or carrier are unsewered, the health officer shall cause all vaults and cesspools to be sufficiently disinfected and kept fly-proof and vermin-proof by screening or other effective arrangements.
  (b) Concurrent disinfection—Sanitary disposal of the bowel discharges is required.

**H 45.07 Anthrax**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation until the lesions have healed
  (c) Reporting required

(2) Contacts—No restrictions

(3) Environment
  (a) Concurrent disinfection of the discharges from lesions and articles soiled therewith.
  (b) Terminal disinfection—Thorough cleaning

**H 45.08 Bacillary Dysentery**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation: None. No person having bacillary dysentery, or who is a carrier of bacillary dysentery shall handle, prepare, or serve food for public consumption which is not subsequently to be cooked, until completion of treatment and two negative stool tests taken not less than one day apart.
  (c) Reporting—All cases and carriers of bacillary dysentery shall be reported to the local health officer. The occupation of such persons shall be forwarded in the report.

(2) Contacts—Restrictions: Quarantine—None. Contacts within the home are prohibited from handling or preparing food for public consumption until two negative stools are obtained.

(3) Environment
  (a) Where the premises occupied by the patient or carrier are unsewered, the health officer shall cause all vaults and cesspools to be sufficiently disinfected and kept fly-proof and vermin-proof by screening or other effective arrangements.
  (b) Concurrent disinfection—Sanitary disposal of the bowel discharges is required.

**H 45.09 Brucellosis**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation: None
  (c) Reporting required

(2) Contacts—No restrictions

(3) Environment
  (a) Concurrent disinfection—None
  (b) Terminal disinfection—None

**H 45.10 Chickenpox**

(1) Patient
  (a) Placard—None
  (b) Restrictions—The patient is to be isolated for seven days at home from date of onset.
  (c) Reporting—All cases are to be reported to the local health officer. The diagnoses of all cases of chickenpox occurring in persons over 15 years of age are to be verified by a physician. Where a physician is not employed by the family, the local board of health is required to furnish a physician for the verification of such diagnosis.

(2) Contacts—Restrictions: Quarantine—None. Well children in the family may attend school but are to be observed by the teacher and excluded if they show any evidence of illness.

(3) Environment—There is to be concurrent disinfection of all articles soiled by discharges from the nose and throat as well as from the lesions.

**H 45.11 Cholera**

(1) Patient
  (a) Placard required
  (b) Restrictions—The patient is to be isolated in a hospital or a well-screened room for 14 days or until the stool is found to be free from cholera vibrio on three consecutive days.
  (c) Reporting—All cases are to be reported to the local health officer within 24 hours.

(2) Contacts—Restrictions: All contacts are to be quarantined for a period of five days from the date of last exposure and until two negative, consecutive cultures are obtained.

(3) Environment

(a) Concurrent disinfection—There is to be prompt and thorough disinfection of the stools and vomitus. Articles used by and in connection with the patient are to be disinfected. Food left by the patient is to be burned.

(b) Terminal disinfection—The room in which a patient was isolated is to be thoroughly cleaned.

**H 45.12 Diarrhea of the Newborn**

(1) Patient

(a) Placard—None

(b) Restrictions—immediate removal of affected baby from nursery to isolation ward. Closure of contaminated nursery to new admissions and suspension of maternity service.

(c) Reporting—The occurrence of any case of diarrhea of the newborn is to be immediately reported to the local health officer in those communities which employ a full-time health officer. In those communities where a full time health officer is not employed, the occurrence of diarrhea of the newborn is to be reported directly to the Wisconsin state board of health.

(2) Contacts—Restrictions: All exposed babies in the nursery are to be cared for by separate medical and nursing personnel.

(3) Environment

(a) All articles within the nursery are to be disinfected as thoroughly as practical.

(b) Terminal disinfection—Thorough cleansing of the premises.

**H 45.13 Diphtheria**

(1) Patient

(a) Placarding required

(b) Restrictions—The patient is to be isolated for at least 10 days and until two consecutive, negative nose and throat cultures, taken not less than 24 hours apart, are obtained.

(c) Reporting—All cases and carriers shall be reported to the local health officer.

(2) Contacts—Restrictions: All intimate contacts are to be quarantined for at least five days and until two consecutive, negative nose and throat cultures are obtained. Children in the family with the patient may not return to school until all persons within the affected household have been shown to no longer carry the etiologic agent.

(3) Environment

(a) All carriers of diphtheria bacilli are to be handled as cases unless laboratory examination demonstrates that the organisms are not virulent.

(b) All articles which have been in contact with the patient and all articles soiled by discharges of the patient are to be concurrently disinfected.

**H 45.14 Encephalitis**

(1) Patient

(a) Placard—None

(b) Restrictions—the patient is to be isolated in a well-screened room for an interval of seven days from the onset of the disease.

(c) Reporting—All cases are to be reported to the local health officer within 24 hours.

(2) Contacts—Restrictions: Quarantine—None.

(3) Environment—Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

**H 45.15 Food Poisonings**

All instances of food poisoning or suspected food poisoning, in which there is reason to believe that the purchase or consumption of the incriminated food occurred at a store or eating place accessible to the general public, shall be reported.

**H 45.16 German Measles**

(1) Patient

(a) Placard—None

(b) Restrictions—Isolation at home for seven days from onset.

(c) Reporting—All cases are to be reported to the local health officer.

(2) Contacts

(a) Restrictions—Quarantine: None

(b) Other children in the family may attend school but are to be observed by the teacher and excluded if they show evidence of illness.

**H 45.17 Hemorrhagic Jaundice**

(1) Patient

(a) Placard—None

(b) Restrictions—Isolation: None

(c) Reporting required

(2) Contacts—No restrictions

(3) Environment

(a) Concurrent disinfection—Urine and other discharges of patient.

(b) Terminal disinfection—None

**H 45.18 Hepatitis, Infectious**

(1) Patient

(a) Placard—None

(b) Restrictions—Isolation during the first week of illness

(c) Reporting required

(2) Contacts—No restrictions

(3) Environment

(a) Concurrent disinfection—Discharges of nose, throat, and bowels of the patient.

(b) Terminal disinfection—None

**H 45.19 Histoplasmosis**

(1) Patient
  (a) Placard—None
  (b) Restrictions—None
  (c) Reporting required
(2) Contacts—No restrictions
(3) Environment—No requirements

**H 45.20 Leprosy**

(1) Patient
  (a) Placard—None
  (b) Restrictions—The patient is to be isolated at home until transferred to a National Leprosarium.
  (c) Reporting required
(2) Contacts—No restrictions
(3) Environment
  (a) Concurrent disinfection—Of all discharges and articles soiled with discharges from the patient.
  (b) Terminal disinfection—Cleansing of premises after removal of patient.

**H 45.21 Malaria**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation in a well-screened room until blood is negative for parasites.
  (c) Reporting required
(2) Contacts—Restrictions: Quarantine—None
(3) Environment—Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

**H 45.22 Measles**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation at home for seven days upon appearance of rash.
  (c) Reporting required
(2) Contacts—Restrictions: Susceptible contacts in the home are to be restricted to the premises beginning the second week after exposure for a period of seven days.
(3) Environment—Concurrent disinfection: All articles soiled with secretions of the nose and throat are to be concurrently disinfected.

**H 45.23 Meningitis, Meningococcal**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation until 48 hours after the institution of treatment with a sulfonamide or penicillin. In the absence of such treatment the patient is to be isolated for two weeks.
  (c) Reporting—The occurrence of meningococcic meningitis is to be reported to the local health officer within 24 hours.
(2) Contacts—Restrictions: Quarantine—None
(3) Environment—There is to be concurrent disinfection of discharges from the nose and throat or articles soiled with these discharges.

**H 45.24 Mumps**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation of patient for at least one week or until disappearance of swelling.
  (c) Reporting required
(2) Contacts — Restrictions: Quarantine — None. Other children in the family may attend school but are to be observed by the teacher and excluded if they show any evidence of illness.

**H 45.25 Ophthalmia Neonatorum**

(1) Patient
  (a) Placard—None
  (b) Restrictions—None provided the patient is under adequate medical supervision.
  (c) Reporting—None except as provided in *Sec. 146.01 (2)* which requires reporting to the local health officer in cases not attended by a physician or midwife.
(2) Contacts—No restrictions
(3) Environment
  (a) Concurrent disinfection of conjunctival discharges and soiled articles.
  (b) Terminal disinfection—Thorough cleaning
(4) Prevention—The attending physician or midwife is required to place two drops of a one per cent solution of silver nitrate in each eye of a newborn child immediately after delivery. Failure to observe this requirement is punishable by a fine of not more than one hundred dollars. *(Sec. 146.01)*

**H 45.26—H 45.32 PARATYPHOID FEVER**

**H 45.26 Paratyphoid Fever—Patient**

(1) Placard—Not required
(2) Restrictions—Isolation for at least one week beyond the time that all symptoms subside and until two negative, consecutive specimens of feces are obtained at least five days apart.
(3) Reporting required

**H 45.27 Paratyphoid Fever—Contacts**

(1) Quarantine—None
(2) Family contacts are not to be permitted to handle food during the period of contact nor before two negative, consecutive stool and urine cultures are obtained.

**H 45.28 Paratyphoid Fever Cases—Environment**

(1) Concurrent disinfection of all bowel and urinary discharges and articles soiled with them.
(2) Terminal disinfection through a thorough cleaning of the premises
(3) Suppression of flies

**H 45.29 Paratyphoid Carrier—Definition**

A person shall be considered a paratyphoid carrier, capable of transmitting the disease to susceptible persons if:

(1) During or following his convalescence from the disease his feces and/or urine have not been proved free from paratyphoid bacilli by examination in a laboratory approved for release cultures (temporary carrier).

(2) He has not suffered from paratyphoid fever within one year, but paratyphoid bacilli are found in his urine or feces when examined in a laboratory approved for release cultures (chronic carrier).

(3) Epidemiological evidence points to such person as the source of one or more cases of the disease and from whom for any reason specimens of urine or feces have not or cannot be obtained for examination in a laboratory approved for release cultures.

**H 45.30 Paratyphoid Carriers—Rules Governing**

(1) The urine and feces of a paratyphoid carrier shall be disposed of in such a manner as not to endanger any public or private water supply or be accessible to insects or rodents.

(2) If food products, which are to be consumed raw by others, are produced on premises occupied by a paratyphoid carrier, the water supply shall be proved free from contamination.

(3) No paratyphoid carrier shall engage in the handling or preparation of any food or drink to be consumed on the premises by others than members of his family with whom he resides or to be consumed off the premises prior to cooking. This restriction shall apply to visitors, roomers, lodgers, and employees.

(4) No paratyphoid carrier shall engage in the occupation of nurse, nursemaid, domestic servant, cook, waiter, dishwasher, or public eating-house employee.

(5) No paratyphoid carrier shall engage in any occupation involving the handling of milk, cream, or milk products, or the utensils used in the production thereof. No paratyphoid carrier shall reside on premises where milk is produced for distribution off the premises unless the carrier, or if he be a minor, his parent or legal guardian, and the owner of the milk-producing cows agree in writing:

(a) That the carrier will not engage in milking or handling of milk, cream, or dairy utensils, nor enter the house or barn where milk is produced or handled.

(b) That no milk or cream is subsequently to be sold nor any utensils used in the production of milk or cream shall be brought into the house occupied by the carrier.

(c) That all persons residing or employed on the premises who are susceptible to paratyphoid shall be vaccinated against paratyphoid fever at least every three years. Where the provisions of such agreement are not followed, distribution and sale of milk from such premises are prohibited.

(6) No paratyphoid carrier shall reside in or be employed in a boarding house or camp.

(7) No carrier shall change his place of residence without notifying the local health officer of his intended residence, who shall immediately inform the state board of health of the facts.

(8) In any situation not covered by the above rules and in which a paratyphoid carrier endangers the public health, the carrier shall observe such recommendations as the state board of health may make for the particular case.

**H 45.31 Paratyphoid Carriers—Release**

Following isolation for paratyphoid fever a person adjudged a temporary carrier may be released from restrictions only after two successive specimens of feces, passed at an interval of not less than five days, shall have been examined in a laboratory approved for release cultures and found free from paratyphoid bacilli; except that if the person is to handle milk, dairy, or food products the number of negative cultures shall be four, two of which shall have been examined in a laboratory approved by the state board of health for release cultures.

**H 45.32 Chronic Paratyphoid Carriers — Conditions for Release**

(1) Each of at least 18 successive specimens of feces taken at intervals of 30 days under conditions that do not permit of substitution have been examined in a laboratory approved for release cultures by the state board of health and found to contain no paratyphoid bacilli.

(2) Where an individual has been found to be excreting the organisms through the urinary tract, then the requirements for release of carrier status under paragraphs **H 45.31** and **H 45.32 (1)** shall apply for urine specimens as well.

**H 45.33 Plague**

(1) Patient

(a) Placard—Required

(b) Restrictions—Isolation of patient in a hospital or well-screened room which is free from vermin for a period of at least two weeks.

(c) Reporting required

(2) Contacts—Restrictions: Quarantine of persons exposed to the pneumonic form of the disease for a period of one week from the date of last exposure.

(3) Environment

(a) Concurrent disinfection of sputum and soiled articles

(b) Extermination of rats and vermin from the premises

**H 45.34 Poliomyelitis**

(1) Patient
- (a) Placard—Not required
- (b) Restrictions—The patient is to be isolated for a period of at least one week from the onset of symptoms, (or for the duration of fever if longer).
- (c) Reporting required

(2) Contacts—Restrictions
- (a) Household contacts under 18 years of age are to be restricted to their homes, for a period of one week from the date of the onset of acute symptoms in the first household case.
- (b) Household contacts who are 16–18 years of age (employed full-time) and who do not come into close contact with children in the course of their occupation shall comply with adult restrictions only.
- (c) Adult household contacts: Teachers and others who come in close contact with children must cease their occupation for an interval of one week from the date of onset of the first household case.

(3) Environment—Concurrent disinfection: All discharges from the nose and throat and bowel are to be concurrently disinfected.

**H 45.35 Psittacosis**

(1) Patient
- (a) Placard—None
- (b) Restrictions—Isolation during the febrile and acute clinical stage of the disease.
- (c) Reporting required

(2) Contacts—No restrictions

(3) Environment
- (a) Concurrent disinfection of all discharges
- (b) Terminal disinfection—Destruction of infected birds

**H 45.36 Rabies**

(1) Patient
- (a) Placard—None
- (b) Restrictions—Isolation: None if the patient is under medical supervision and the immediate attendants are warned of possibility of inoculation by human virus.
- (c) Reporting required

(2) Contacts—No restrictions

(3) Environment
- (a) Concurrent disinfection of saliva of patient and articles soiled therewith.
- (b) Terminal disinfection—None

**H 45.37 Rheumatic Fever (Active)**

(1) Patient
- (a) Placard—None
- (b) Restrictions—None
- (c) Reporting required

(2) Contacts—No restrictions

(3) Environment—No requirements

**H 45.38 Salmonellosis (Other Than Typhoid Fever and Paratyphoid Fever)**

(1) Patient
- (a) Placard—Not required
- (b) Restrictions
  1. Isolation—Not required
  2. All cases will be considered convalescent carriers after clinical recovery unless they have two successive negative fecal cultures, taken not less than 24 hours apart, and performed by a laboratory approved for such purposes by the state board of health. After six months they shall be considered chronic carriers.
- (c) Reporting required

(2) Carriers
- (a) All carriers (convalescent and well carriers) are restricted from engaging in food handling activity other than in the preparation of food for their own immediate families.
- (b) No carrier shall be employed in an occupation requiring close personal contact with other individuals, such as caring for disabled or sick individuals or infants in hospitals and nurseries.
- (c) Chronic carriers may be released after three consecutive stool cultures taken not less than 24 hours apart have been found to be negative for Salmonella organisms when cultured by a laboratory approved for such purposes by the state board of health.

**H 45.39 Smallpox**

(1) Patient
- (a) Placard required
- (b) Restrictions—Isolate until the disappearance of all scabs and crusts.
- (c) Reporting required

(2) Contacts—Restrictions: Quarantine for 18 days from date of last exposure unless a successful vaccination has been obtained within three days of exposure.

(3) Environment
- (a) Concurrent disinfection—No article is to leave the immediate surroundings of the patient without boiling or equally effective disinfection.
- (b) Terminal disinfection — Thorough cleaning of the premises

**H 45.40 Streptococcal Infections, Respiratory (Including Scarlet Fever, Streptococcal Sore Throat, and "Septic Sore Throat")**

(1) Patient
- (a) Placard—None
- (b) Restrictions—The patient shall be isolated until the complete disappearance of inflammation and discharges from the nose and throat, ears, or suppurating glands; and in

any case for not less than seven days from onset.

(c) Reporting required

(2) Contacts

(a) Household contacts — It is recommended that household contacts be kept under medical observation for the development of streptococcal disease during the incubation period. Restriction of contacts is not required, except at the discretion of the local board of health, and as specified in H 49.10.

(b) Other contacts—No restrictions are required

(3) Environment

(a) Concurrent disinfection—All articles which have been soiled by purulent discharges and all articles which have been in contact with the patient are to be concurrently disinfected.

(b) Terminal disinfection—A thorough cleaning of contaminated objects, scrubbing of floors, and sunning of blankets to prevent dissemination of infected particles.

**H 45.41 Streptococcal Diseases Other Than Respiratory Erysipelas and Puerperal Infection**

(1) Patient

(a) Placard—None

(b) Restrictions—The patient is to be isolated for the duration of the acute stage of the disease.

(c) Reporting—None

(2) Contacts—Restrictions: None

(3) Environment

(a) Concurrent disinfection—Careful disposal of dressings and discharges from the patient.

(b) Terminal disinfection—General thorough cleaning of blankets, linen, and room.

**H 45.42 Tetanus**

(1) Patient

(a) Placard—None

(b) Restrictions—None

(c) Reporting required

(2) Contacts—No restrictions

(3) Environment

(a) Concurrent disinfection—None

(b) Terminal disinfection—None

**H 45.43 Tinea Capitas (Ringworm Scalp)**

(1) Patient

(a) Placard—None

(b) Restrictions—Exclusion from school until recovery unless

1. Under continuous treatment of physician licensed to practice medicine, and wears a suitable head covering until cured; or
2. Separate classroom provided for infected cases.

(c) Reporting required

(2) Contacts—Upon discovery of a clinical case of ringworm of the scalp, all contacts under 15 and all school children in the classroom should be inspected and examined with suitable filtered ultra-violet light. Resurveys should be continued until one month after last case is detected.

(3) Environment

(a) Concurrent disinfection—Stocking caps and inexpensive head coverings should be frequently laundered and destroyed by burning after use.

(b) Terminal disinfection—None

**H 45.44 Trachoma**

(1) Patient

(a) Placard—None

(b) Restrictions — Isolation: None, if under medical supervision

(c) Reporting required

(2) Contacts—No restrictions

(3) Environment

(a) Concurrent disinfection of eye discharges and articles soiled therewith.

(b) Terminal disinfection—None

**H 45.45 Trichinosis**

(1) Patient

(a) Placard—None

(b) Restrictions—None

(c) Reporting required

(2) Contacts—No restrictions

(3) Environment

(a) Concurrent disinfection—None

(b) Terminal disinfection—None

**H 45.46 Tularemia**

(1) Patient

(a) Placard—None

(b) Restrictions—Isolation: None

(c) Reporting required

(2) Contacts—No restrictions

(3) Environment

(a) Concurrent disinfection of discharges from the ulcer, lymph glands, or conjunctival sac.

(b) Terminal disinfection—None

**H 45.47–45.53 TYPHOID FEVER**

**H 45.47 Typhoid Fever—Patient**

(1) Placard—Not required

(2) Restrictions—Isolation for at least one week beyond the time that all symptoms subside and until two negative, consecutive specimens of feces are obtained at least five days apart.

(3) Reporting required

**H 45.48 Typhoid Fever—Contacts**

(1) Quarantine—None

(2) Family contacts are not to be permitted to handle food during the period of contact nor before two negative, consecutive stool and urine cultures are obtained.

**H 45.49 Typhoid Fever Cases—Environment**

(1) Concurrent disinfection of all bowel and urinary discharges and articles soiled with them.

(2) Terminal disinfection through a thorough cleaning of the premises

(3) Suppression of flies

**H 45.50 Typhoid Carrier—Definition**

A person shall be considered a typhoid carrier, capable of transmitting the disease to susceptible persons if:

(1) During or following his convalescence from the disease his feces and/or urine have not been proved free from typhoid bacilli by examination in a laboratory approved for release cultures (temporary carrier).

(2) He has not suffered from typhoid fever within one year, but typhoid bacilli are found in his urine or feces when examined in a laboratory approved for release cultures (chronic carrier).

(3) Epidemiological evidence points to such person as the source of one or more cases of the disease and from whom for any reason specimens of urine or feces have not or cannot be obtained for examination in a laboratory approved for release cultures.

**H 45.51 Typhoid Carriers—Rules Governing**

(1) The urine and feces of a typhoid carrier shall be disposed of in such a manner as not to endanger any public or private water supply or be accessible to insects or rodents.

(2) If food products which are to be consumed raw by others are produced on premises occupied by a typhoid carrier, the water supply shall be proved free from contamination.

(3) No typhoid carrier shall engage in the handling or preparation of any food or drink to be consumed on the premises by others than members of his family with whom he resides or to be consumed off the premises prior to cooking. This restriction shall apply to visitors, roomers, lodgers, and employees.

(4) No typhoid carrier shall engage in the occupation of nurse, nursemaid, domestic servant, cook, waiter, dishwasher, or public eating-house employee.

(5) No typhoid carrier shall engage in any occupation involving the handling of milk, cream, or milk products, or the utensils used in the production thereof. No typhoid carrier shall reside on premises where milk is produced for distribution off the premises unless the carrier, or if he be a minor, his parent or legal guardian, and the owner of the milk-producing cows agree in writing:

(a) That the carrier will not engage in milking or handling of milk, cream, or dairy utensils, nor enter the house or barn where milk is produced or handled.

(b) That no milk or cream is subsequently to be sold nor any utensils used in the production of milk or cream shall be brought into the house occupied by the carrier.

(c) That all persons residing or employed on the premises who are susceptible to typhoid shall be vaccinated against typhoid fever at least every three years.

Where the provisions of such agreement are not followed, distribution and sale of milk from such premises are prohibited.

(6) No typhoid carrier shall reside in or be employed in a boarding house or camp.

(7) No carrier shall change his place of residence without notifying the local health officer of his intended residence, who shall immediately inform the state board of health of the facts.

(8) In any situation not covered by the above rules and in which a typhoid carrier endangers the public health, the carrier shall observe such recommendations as the state board of health may make for the particular case.

**H 45.52 Typhoid Carriers—Release**

Following isolation for typhoid fever a person adjudged a temporary carrier may be released from restrictions only after two successive specimens of feces, passed at an interval of not less than five days, shall have been examined in a laboratory approved for release cultures and found free from typhoid bacilli; except that if the person is to handle milk, dairy, or food products the number of negative cultures shall be four, two of which shall have been examined in a laboratory approved by the state board of health for release cultures.

**H 45.53 Chronic Typhoid Carriers—Conditions for Release**

(1) Each of at least 18 successive specimens of feces taken at intervals of 30 days under conditions that do not permit of substitution have been examined in a laboratory approved for release cultures by the state board of health and found to contain no typhoid bacilli.

(2) Where an individual has been found to be excreting the organisms through the urinary tract, then the requirements for release of carrier status under paragraphs **H 45.52** and **H 45.53 (1)** shall apply for urine specimens as well.

**H 45.54 Typhus**

(1) Patient
- (a) Placard—None
- (b) Restrictions—Delousing, isolation in vermin-free room during febrile period.
- (c) Reporting required

(2) Contacts—Restrictions: None required if delousing carried out

(3) Environment
- (a) Concurrent disinfection—Use of insecticide powders on clothing and bedding and special treatment of hair for nits.
- (b) Terminal disinfection—None

**H 45.55 Whooping Cough**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation for three weeks after onset of typical paroxysms, or a total of 28 days from onset of the catarrhal stage.
  (c) Reporting required

(2) Contacts—Restrictions Other children in the family may attend school but are to be observed by the teacher and excluded if they evidence any symptoms of illness. Those children exposed to whooping cough who develop coughs or colds must be kept in isolation in their home until a diagnosis is established.

(3) Environment
  (a) Concurrent disinfection of the discharges from the nose and throat and of articles soiled with such discharges.
  (b) Terminal disinfection—a thorough cleaning of the premises

**H 45.56 Yellow Fever**

(1) Patient
  (a) Placard—None
  (b) Restrictions—Isolation in a well-screened room for seven days
  (c) Reporting required on all cases to the local health officer within 24 hours.

(2) Contacts—Restrictions: Quarantine—None

(3) Environment—Concurrent disinfection: None except for the purpose of destroying mosquitoes in the house occupied by the patient and in the nearest neighboring dwellings.

**H 46.01–H 46.03 TUBERCULOSIS**

**H 46.01 Tuberculosis—Patient**

(1) Placard—None

(2) Restrictions
  (a) All individuals afflicted with tuberculosis of the lungs in the communicable form or reasonably suspected of being so afflicted shall exercise all reasonable precautions so as to prevent the infection of others with whom they may come in contact. The principal reasonable precautions are declared to be:
    1. Depositing sputum in a special receptacle and disposing of material by burning or thorough disinfecting.
    2. Preventing spraying when coughing by coughing into a container or paper napkin held to the mouth or nose.
    3. Using individual eating utensils sterilized by boiling after each use.
    4. Using separate towels.
    5. Sleeping alone.
    6. Avoiding coming in contact with other individuals on all possible occasions.
    7. Refraining from handling liquids or foodstuffs to be consumed by others or the utensils connected with such handling.
  (b) Any individual afflicted with tuberculosis of the lungs in the communicable form, diagnosed as such by a licensed physician or as shown by X-ray or the presence of tubercle bacilli in the sputum, in order to protect others from becoming infected, may be isolated on his premises by the local board of health or the health officer on the direction of the state board of health or state health officer, or by the full-time medical health officer of any city or county with a population of 250,000 or more within his jurisdiction.
  (c) A placard shall be posted in a conspicuous position on the premises, with the words "communicable disease" in letters not less than two inches high.
  (d) The local board of health or health officer may employ as many persons as are necessary to execute its orders and properly guard any patient in isolation if isolation is violated or intent to violate isolation is manifested. Such persons shall be sworn in as guards, shall have police powers, and may use all necessary means to enforce the state laws for the prevention and control of communicable diseases, or for the enforcement of these rules and regulations.
  (e) The expense of maintaining isolation, including examinations and tests to determine the presence or communicability of the disease, and the enforcement of isolation on the premises shall be paid by the city, incorporated village, or town upon order of the local board of health. The expenses for necessary nurses, medical attention, food, and other articles needed for the comfort of the afflicted person shall be charged against him or whoever is liable for his support. Indigent cases shall be cared for at public expense.
  (f) Any individual who has been isolated on the premises under provision of these rules shall be released from such isolation by the local board of health or health officer on direction of the state board of health or state health officer or by the full-time medical health officer of any city or county with a population of 250,000 or more within his jurisdiction when in the opinion of said health officer the isolation is no longer necessary to protect others from becoming infected.
  (g) No person with tuberculosis of the lung or other part of the respiratory tract in the communicable form, or reasonably believed to be suffering from such disease, shall be permitted to attend or frequent any school except open-air schools especially equipped for the purpose until the health officer of the municipality where the school is situated furnishes a written cer-

tificate stating that the individual is free from a communicable form of tuberculosis. Such certificate shall be issued only after thorough examination by a licensed physician in a manner satisfactory to the state board of health.

(h) If an individual afflicted with tuberculosis in a communicable form shall leave the sanatorium against the advice of the medical superintendent or medical supervisor, such an individual shall be reported to the local board of health and may be isolated upon his premises as provided in Section (b) if in the opinion of the state board of health or the state health officer or of the full-time medical health officer of cities or counties with a population of 250,000 or more, agree that isolation is necessary in order to protect others from becoming infected.

(i) The local health officer or an individual delegated by him shall visit all individuals isolated for tuberculosis at least once every 15 days to ascertain that the isolation is being maintained and to ascertain whether to make recommendations for release from isolation or for admission to a tuberculosis sanatorium.

(j) Any individual isolated for tuberculosis may obtain release from such isolation by being admitted to a tuberculosis sanatorium.

(k) Individuals afflicted with tuberculosis in any form and diagnosed as such by a competent physician shall exercise every care and precaution for the protection of others.

(3) Reporting—By name to local health officer

**H 46.02 Tuberculosis—Contacts: No restrictions**

**H 46.03 Tuberculosis Cases—Environment: Disinfection**

All handkerchiefs, towels, cloths, eating utensils and other contaminated material used by a person with tuberculosis shall receive appropriate disinfection before coming in contact with others. Upon the death or removal of a person with tuberculosis the health officer shall require disinfection of the premises occupied by the patient by a thorough washing of the woodwork by soap and water or a disinfectant, boiling of the dishes and contaminated fabrics, and a thorough sunning of material which cannot be subjected to other disinfection.

(Note: It is the intent of these rules and regulations to give reasonable protection to the public from exposure to an individual afflicted with pulmonary tuberculosis in the communicable form.)

**H 47.01–47.12 VENEREAL DISEASES**

**H 47.01 Venereal Diseases**

The state board of health declares the following venereal diseases, namely, syphilis, gonorrhea, and chancroid as contagious, infectious, communicable and dangerous to the public health.

**H 47.02 Venereal Disease—All Infected Persons Subject to Control**

All persons having venereal disease shall be subject to such control as public safety requires.

**H 47.03 Venereal Disease—Who Is to Report**

Any physician who attends, treats, or examines a person with venereal disease in communicable form; and any superintendent or manager of a hospital, dispensary, charitable or penal institution having knowledge of any such case not known to be previously reported, shall report such case to the state board of health. Such report shall be by designated number, age, sex, conjugal condition, and duration of disease. The physician shall inquire into the source of infection and shall report any person known to a reasonable certainty to be the source by name and address to the state board of health. Any person knowing of a case of venereal disease not under the care of a physician and believed to be a menace to the public health shall report the name and address directly to the state board of health.

**H 47.04 Venereal Disease—Reporting of Cases Delinquent in Treatment**

Whenever any person suffering from syphilis, gonorrhea or chancroid in a communicable form shall fail to return to the physician treating such person in reasonable time, such person shall be reported by name and address to the state board of health as delinquent in treatment.

**H 47.05 Examination of Certain Classes Suspected of Having Venereal Disease**

(1) It shall be the duty of each superintendent, manager or physician of any state, county, municipal, charitable, or correctional institution, the warden of the state prison, the sheriff, and other keepers of any jail or other penal institution to cause an examination to be made of all inmates suspected of having a venereal disease and said examination shall be made by a method satisfactory to the state board of health. Vagrants, prostitutes, frequenters of houses of prostitution, and persons guilty of illicit cohabitation are hereby declared to be reasonably suspected to have venereal disease.

(2) Any such person found to be infected with any of the venereal diseases in a communicable stage shall be kept in such quarters as not to expose others. Such persons and all legally committed persons with a venereal disease which is communicable to others, at expiration of commitment shall hereby be considered under quarantine and shall so remain until satisfactory arrangements can be made for care and treatment by a licensed physician at place of subsequent residence or until other disposition of the case is made by the state board of health.

**H 47.06 Venereal Disease Cases—Isolation**

Whenever a case or suspected case of venereal disease is found on premises where the case cannot

be properly controlled during the period of infectiousness, or whenever a case of venereal disease in the infectious stage refuses or neglects care or treatment by a physician licensed to prescribe drugs, or is unmanageable and other persons are endangered, a placard may be placed on the premises occupied by the patient. Such placard shall be applied in emergency and not in lieu of commitment to an institution under Chapter 143.07, Laws of Wisconsin. The placard sign shall have the words "Communicable Disease." Violation of the requirements imposed by the placard shall be deemed a violation of these regulations. The local health officer shall be required by the state board of health to impose such isolation and enforce its requirements.

**H 47.07 Venereal Disease—Examination of Sexual Contacts**

All persons reported to be sexual contacts by any person with venereal disease in a communicable form shall be regarded as suspected cases and may be required by an official of the state board of health to be examined by a physician, in a manner satisfactory to the state board of health.

**H 47.08 Venereal Disease—Indigents: Treatment Facilities**

Local health officers and local boards of health shall cooperate with the state board of health in establishing treatment facilities for indigent persons with venereal disease. Local health officers shall report to the state board of health all cases of venereal disease reported to them.

**H 47.09 Venereal Disease—Forbidden Occupations**

Persons suspected to be or knowing themselves to be afflicted with a communicable venereal disease shall not engage in the care or nursing of children or of the sick, nor shall they engage in any occupation the nature of which is such that their infection may be communicated to others. In the interest of the public health a medical health officer or officer of the state board of health may confidentially inform any person so endangered.

**H 47.10 Issuing Certificates of Freedom From Venereal Disease Forbidden**

No physician or health officer shall issue certificates of freedom from any venereal disease to any person except those certificates required by law for marriage licenses and those required by local ordinances to be issued to local health officers. No person shall carry or exhibit such certificates to other persons or show, for immoral purposes, venereal disease reports from any laboratory. Such procedure is declared by the state board of health to be inimical to public health and public welfare.

**H 47.11 Venereal Disease—Minors**

The parents or guardians of minors acquiring venereal disease shall, when notified, be legally responsible for the compliance of such minors with the requirements of these regulations.

**H 47.12 Venereal Disease—Definition of Communicability**

All cases of venereal disease shall be regarded as communicable until the following requirements have been met:

(1) **Syphilis*** Until open sores, ulcers, rashes, syphilitic sore throat, or other open syphilitic lesions are healed; and also until satisfactory care and treatment as hereinafter defined has been given to any of the following: Pregnant women with syphilis; females who have given birth to a syphilitic child; syphilitic persons at any stage of the disease who, reasonable evidence indicates, are promiscuous in sexual relations and are a menace to others; and persons with early syphilis not adequately treated.

(Note: Adequate treatment shall be considered to be the administration of not less than 20 doses of arsenicals and 20 doses of heavy metal or equally effective treatment by a physician licensed to prescribe drugs. This other effective treatment shall be such as considered adequate by the state board of health.)

(2) **Gonorrhea**

(a) Male

1. Freedom from discharge
2. Clear urine, no shreds
3. Urethral smears must be negative for gonococci on four successive examinations at intervals of not less than one week.
4. Prostatic smears negative to gonococci on two successive tests, not less than one month after conclusion of specific treatment.
5. When penicillin is used for the treatment of gonorrhea, a blood test for syphilis shall be taken at monthly intervals for a three-month period.

(b) Female

1. No unusual vaginal discharge
2. Two successive negative examinations for gonococci of the secretions of the urethra, vagina, and of the cervix with an interval of at least 48 hours, and repeated for four successive weeks.
3. When penicillin is used for the treatment of gonorrhea, a blood test for syphilis shall be taken at monthly intervals for a three-month period.

(Note: The labia should be held apart and a swab applied so as to express any secretions from Skenes or Bartholin's glands, which is then taken up on the swab.

In preparing urethral slides the finger should be inserted in the vagina and expression made on the floor of the urethra from within outward, the cotton-

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* *Does not apply to Section 143.07, subsection 4.*

tipped probe being then introduced well into the meatus. In procuring a smear from the cervix a vaginal speculum should be introduced and the cervix well exposed. All secretions should be mopped away from the external os before taking the smear. After the cervix is well dried a probe tightly wound with cotton should be inserted in the cervical canal and rotated several times.)

(3) **Chancroid.** Until all lesions are healed.

**H 49.01 School Attendance**

(1) All teachers, school authorities, and health officers having jurisdiction shall not permit the attendance in any private, parochial, or public school of any pupil afflicted with a severe cough, a severe cold, itch, scabies, lice, or other vermin, ringworm, impetigo, epidemic jaundice, Vincent's angina (trench mouth), infectious conjunctivitis (pink eye), or any contagious skin disease, or who is filthy in body or clothing, or who has any communicable disease so designated by the state board of health unless specifically exempted in the rules. The teachers in all schools shall, without delay, send home any pupil who is obviously sick even if the ailment is unknown, and said teacher shall inform the parents or guardians of said pupil and also the local health officer as speedily as possible, and said health officer shall examine into the case and take such action as is reasonable and necessary for the benefit of the pupils and to prevent the spread of infection.

(2) Parents, guardians, or other persons having control of any child who is sick in any way, or who is afflicted with any disease covered by this rule, shall not permit said child to attend any public, private or parochial school or to be present in any public place.

**H 49.02 Exclusion From School, Assemblages, and Public Conveyances**

No person suffering from any communicable disease so designated by the state board of health shall be admitted to any public, parochial or private school, college or Sunday school, or shall enter any theatre, assemblage, or railway car, street car, vessel, or steamer, or other public conveyance, except as specifically provided in the communicable disease rules.

**H 49.03 Books not to be Taken into Infected Homes**

(1) Schoolbooks or books from public or circulating libraries shall not be taken into any house placarded for communicable disease and if schoolbooks or library books have already been taken in such house they shall be destroyed by the owner or library authorities or thoroughly disinfected.

(2) Disinfection of books—In cases where it is desirable to disinfect books which may have become infected with dangerous communicable disease the following requirements must be followed:

(a) Library books which have been in a placarded home should be withheld from circulation for a period of 15 days and so arranged each day that the sunlight can reach the maximum number of surfaces.

(b) Books used by a tubercular person should either be destroyed or withheld from circulation for at least one month and during this time kept standing in the sunlight opened so that the rays of the sun can reach the maximum number of pages. Surfaces should be changed from day to day. Time and sunlight are recommended as the best means to accomplish the destruction of infectious material deposited upon books.

**H 49.10 Sale of Milk and Dairy Products from Infected Home Restricted**

The sale or use of milk and dairy products from a place where cholera (Asiatic), diphtheria, plague, smallpox, respiratory streptococcal infections (including scarlet fever and streptococcal sore throat), typhoid fever, paratyphoid fever, or other salmonella disease is found to exist is strictly forbidden unless the milk is handled, milk utensils washed and stock cared for and the product transported by persons disassociated from the infected individual. The adequacy of such disassociation shall be determined by the local health officer or the state board of health. The handling by the infected person of milk or milk products for sale, or stock, equipment, or other utensils used to produce such products is forbidden under any circumstances.

**H 49.15 Release Cultures**

Where release cultures are required in communicable diseases, such cultures shall be examined in a laboratory approved by the state board of health for such purposes.

**H 49.20 Transporting Cases**

When it is necessary to transport a person suffering with a dangerous communicable disease from one town, village or city to another, the consent of the health officer where the patient lives and also the health officer of the town, village, or city to which the patient will be transported must first be obtained. Transportation must be made by private conveyance and proper precautions exercised to prevent needless exposure of all persons who may come in contact with the patient during transit.

**H 49.25 Mail in Placarded Home**

No mail or other materials shall be sent from a placarded home unless such mail or materials have been prepared and disinfected under the direction of the local health officer.

**H 17.06 Public Funerals Prohibited**

(1) Public or church funerals shall not be held for persons dead of smallpox. Every person who

attends the funeral, including members of the family, shall, within 24 hours of attending the funeral or exposure, submit to vaccination for smallpox or produce evidence from a physician of successful vaccination within the past two years.

(2) Whenever death is due to cholera (Asiatic), diphtheria, poliomyelitis, plague, or scarlet fever, the household and family contacts of the deceased shall not be permitted to attend public or church funerals for the deceased nor to have any association with the public until the specific restrictions governing contacts have been fulfilled.

(3) The above rules shall apply to funerals of those dead from suspected cases as well as diagnosed cases of the diseases above specified, but shall not apply to those dying from late complications of such diseases after the communicable period is past, and after the family is released from quarantine.

(4) During periods of epidemic, diseases of any nature found sufficiently malignant to justify private funerals and in the case of death from unusual forms of virulent disease, apparently communicable in nature, the local board of health with the consent of the state board of health may prohibit public funerals of those dead from such diseases.

**Rules Governing Approval of Laboratories for Doing Serological Tests as Required by the Marriage License Law (Chapter 245.10)**

**H 37.01** Upon application, a laboratory may be approved as competent to make the serological tests required prior to marriage under *chapter 245.10*, provided that:

(1) The laboratory is under the adequate supervision of a licensed doctor of medicine who is a recognized pathologist; or

(2) The laboratory has had a thorough evaluation by the Board covering qualifications of personnel, supervision, physical equipment, and the techniques and procedures used by the laboratory.

**H 37.02** Whenever the Board is in doubt as to the character or extent of the supervision provided under subparagraph **H 37.01 (1)**, the evaluation provided under subparagraph **H 37.01 (2)** shall precede the approval of the laboratory.

**H 37.03** If there is change in directorship or supervision of the laboratory it must be reported to the state board of health and the laboratory must reapply for approval.

**H 37.04** The Board may withdraw approval of a laboratory upon the submission of evidence satisfactory to the Board that the extent or character of the laboratory supervision is inadequate or that quality of the work performed by the laboratory is not up to acceptable standards.

## CODE OF NECROPSY PAMPHLET AVAILABLE

All hospitals and pathologists have been supplied with copies of the Code of Necropsy Procedure, developed by a special committee of the State Medical Society and the Wisconsin Funeral Directors Association in 1952. The Code was published in the January 1953 issue of *The Wisconsin Medical Journal* (pages 23–25). Additional supplies have been sent hospitals and the Wisconsin Society of Pathologists in the past month.

If you do not have access to this material by reference to the January 1953 issue of *The Wisconsin Medical Journal* or the other sources indicated, a copy will be sent you, upon request, so long as the supply lasts.

# Officers of State Boards and Commissions

## State Board of Health

*Members of the Board*

Stephen E. Gavin, M. D., President, Fond du Lac, 1957
Samuel L. Henke, M. D., Vice-President, Eau Claire, 1960
Carl N. Neupert, M. D., Secretary and State Health Officer, Madison, ex officio
William T. Clark, M. D., Janesville, 1956
Carl D. Neidhold, M. D., Appleton, 1959
Forrester Raine, M. D., Milwaukee, 1954
Stephen Cahana, M. D., Milwaukee, 1955
Woodruff Smith, M. D., Ladysmith, 1958

*Bureaus, Divisions, and Units of State Board of Health*

Carl N. Neupert, M. D., State Health Officer
E. H. Jorris, M. D., Assistant State Health Officer

**Section on General Administration**

E. H. Jorris, M. D., Director

Division of Staff Services
Division of Personnel—Henry Kjentvet, Director
Division of Statistical Services—Vivian B. Holland, Statistician
Division of Fiscal Services—Fred E. Brown, Director
Division of Internal Services—Lenore Brandon, Supervisor
Division of Laboratories—W. D. Stovall, M. D., Director
Bureau of Vital Statistics—Paul Weis, Assistant State Registrar
Division of Dental Education—Francis A. Bull, D. D. S., Director
Division of Health Education—Philip Dykstra, Director
Division of Hospital and Related Services—Vincent F. Otis, Director
Division of Cosmetology—Kathleen Bower, Supervisor
Division of Barbering—Thomas D. Ritchie, Supervisor
Division of Funeral Directing & Embalming—Helen Kjelson, Supervisor

**Section on Preventable Diseases**

Milton Feig, M. D., Director
Bureau of Communicable Diseases—Milton Feig, M. D., Director
Division of Tuberculosis Control—Milton Feig, M.D., Acting Director
Division of Venereal Disease Control—A. L. Van Duser, M. D., Director
Division of Cancer Control—A. L. Van Duser, M. D., Director
Division of Heart Disease Control—Milton Feig, M. D., Acting Director

**Section on Environmental Sanitation**

O. J. Muegge—State Sanitary Engineer
Harvey Wirth—Assistant State Sanitary Engineer
Bureau of Sanitary Engineering—Harvey Wirth, Director
Division of Plumbing—Walter Spencer, Supervisor
Division of Well Drilling—Thomas Calabresa, Supervisor
Division of Rendering and Slaughtering—Arthur F. Rizzi, Supervisor
Division of Water Pollution Control—T. F. Wisniewski, Director
Milk Sanitation—C. K. Luchterhand, Sanitarian

**Section on Maternal and Child Health**

Amy Louise Hunter, M. D., Director
Bureau of Maternal and Child Health—Amy Louise Hunter, M. D., Director
Division of Child Guidance—Vacancy
Division of Nutrition—Lucile K. Billington, Supervisor

**Section on Local Health Administration**

Allan Filek, M. D., Director
Bureau of Public Health Nursing—Janet Jennings, R. N., Director
Division of Industrial Hygiene—William L. Lea, Director
Division of Hotels and Restaurants—Harold E. Olsen, Supervisor
Division of Local Health Administration—Allan Filek, M. D., Director

**District Health Offices**

No. 1—602 Insurance Building, Madison
Health Officer: (Vacancy)
Counties included: Columbia, Dane, Grant, Green, Iowa, Jefferson, Lafayette, Rock, and Sauk

No. 2—Municipal Building, Elkhorn
Health Officer: Margaret E. Hatfield, M.D.
Counties included: Kenosha, Milwaukee, Racine, Walworth, and Waukesha

No. 3—146 Forest Avenue, Fond du Lac
Health Officer: (Vacancy)
Counties included: Calumet, Dodge, Fond du Lac, Manitowoc, Ozaukee, Sheboygan, Washington, and Winnebago

No. 4—Rusk Avenue at Montgomery, P. O. Box 251, Sparta
Health Officer: John A. Van Susteren, M.D.

Counties included: Buffalo, Crawford, Jackson, Juneau, La Crosse, Monroe, Pepin, Richland, Trempealeau, and Vernon

No. 5—City Hall, P. O. Box 270, Wisconsin Rapids
Health Officer: G. G. Shields, M.D.
Counties included: Adams, Clark, Green Lake, Marathon, Portage, Marquette, Waushara, and Wood

No. 6—1136 West Mason Street, Box 383, Green Bay
Health Officer: G. M. Shinners, M.D.
Counties included: Brown, Door, Kewaunee, Marinette, Oconto, Outagamie, Shawano, and Waupaca

No. 7—417½ North Bridge Street, Chippewa Falls
Health Officer: R. E. Graber, M.D.
Counties included: Barron, Burnett, Chippewa, Douglas, Dunn, Eau Claire, Pierce, Polk, Rusk, St. Croix, Sawyer, and Washburn

No. 8—City Hall, Rhinelander
Health Officer: Frances Cline, M.D.
Counties included: Ashland, Bayfield, Florence, Forest, Iron, Langlade, Lincoln, Oneida, Price, Taylor, and Vilas

## State Board of Public Welfare

(Created by act of 1939 legislature to supplant the State Board of Control and combine certain other agencies; reorganized by act of 1949 legislature.)

*Members of the Board*

William H. Studley, M. D., Milwaukee, 1959
Mr. Harold W. Story, vice-chairman, Milwaukee, 1957
Mrs. Harrison L. Garner, Madison, 1959
Mr. Ralph Uihlein, Milwaukee, 1957
W. D. Stovall, M. D., chairman, Madison, 1955
Mrs. Karl Kleinpell, Cassville, 1955
Mr. Leo Jelinske, Shawano, 1955
Mr. Earl M. Hale, Eau Claire, 1959
Mrs. C. R. Beck, secretary, West Allis, 1957

*Executive Staff*

Mr. George M. Keith, Madison, Acting Director

**Division of Corrections**
Mr. Russell G. Oswald, Madison, Director

**Division of Mental Hygiene**
Leslie A. Osborn, M. D., Madison, Director

**Division of Public Assistance**
Mr. Thomas J. Lucas, Sr., Madison, Director

**Division of Business Management**
Mr. Wilbur J. Schmidt, Madison, Director

**Division for Children and Youth**
Mr. Frederick DelliQuadri, Madison, Director

## Basic Science Examiners

Prof. Michael F. Guyer, President, University of Wisconsin, 138 North Prospect Avenue, Madison 5, Wisconsin, 1955
Prof. W. H. Barber, Secretary, Ripon College, 621 Ransom Street, Ripon, Wisconsin, 1957
Prof. George G. Town, University of Wisconsin Extension Division, 623 W. State Street, Milwaukee, Wisconsin, 1959

## State Board of Medical Examiners

J. W. Prentice, M. D., President, 522 West Second Street, Ashland, 1955
E. C. Murphy, D. O., 314 East Grand Avenue, Eau Claire, 1957
Alvin G. Koehler, M. D., 46 Washington Boulevard, Oshkosh, 1955
Jerry W. McRoberts, M. D., 1011 North Eighth Street, Sheboygan, 1955
Clifford A. Olson, M. D., Baldwin, 1957
Thos. W. Tormey, Jr., M. D., Secretary, 1140 State Office Building, Madison, 1955
Millard Tufts, M. D., 208 East Wisconsin Avenue, 1957
John A. Schindler, M. D., 921 Sixteenth Avenue, Monroe, 1957

## Wisconsin Industrial Commission

*Members of the Commission*

Mr. Voyta Wrabetz, Chairman, 1955
Mr. R. G. Knutson, 1957
Mr. A. W. Enright, 1959
Miss Helen E. Gill, Secretary

**Workmen's Compensation Department**
Mr. Harry A. Nelson, Director

**Unemployment Compensation Department**
Mr. Paul R. Raushenbush, Director

**Safety and Sanitation Department**
Mr. O. T. Nelson, Director

**Woman and Child Labor Department**
Maud Swett, Director

## State Board of Vocational and Adult Education

E. J. Fransway, Employee member_____Wauwatosa
Mrs. Erna Cartwright, Employee member__Oshkosh
Frank C. Horyza, Employee member_____Superior
Alfred A. Laun, Employer member_____Kiel

Robert L. Pierce, Employer member_____Menomonie
Morton Frost, Employer member_____Kenosha
John Last, Farmer member_____Lake Mills
T. E. Hamilton, Farmer member_____Westfield
Elmer Wilkins, Farmer member_____Platteville
G. E. Watson, ex officio_____Madison
Voyta Wrabetz, ex officio_____Madison
C. L. Greiber, ex officio_____Madison
State Director, State Board of Vocational and Adult Education

*Rehabilitation Division*

**State Office**

Room 320, State Office Building, Madison

John A. Kubiak_____Chief
J. H. Brown_____Assistant chief
Charles Beardsley
_____Guidance, Training and Placement
Irene M. Dunn_Finances and Mentally Handicapped
A. E. Towne_____Medical Service
Mrs. Mary F. Beyer_____Homecraft
Edward J. Pfeifer_____Psychological Service
Milton Feig, M. D.
_____Medical Administrative Consultant (part time)
Mrs. Inez F. Belyea_____Medical Social Worker (part time)
Mrs. Thelma Peckham_____Statistician

**District Offices**

Madison_____Vocational School Building, 211 North Carroll Street, Room 458
C. D. Rejahl, District Supervisor

Milwaukee Vocational School Building, 1015 North Sixth Street, Room 222
L. A. Rumsey, District Supervisor

Green Bay Vocational School Building, 200 South Broadway
A. W. Bouffard, District Supervisor

Eau Claire_____8½ South Farwell Street
Melvin J. Chada, District Supervisor

**Local Offices**

La Crosse Vocational School Building
Carl J. Haase, Case Supervisor

Racine_____828 Center Street
V. C. Bryan, Case Supervisor

Wausau Vocational School Building
L. J. Schultz, Case Supervisor

Superior_____917 Tower Avenue
H. C. Ritzman, Case Supervisor

**DIVISION ON REHABILITATION OF COMMISSION ON STATE DEPARTMENTS**

R. G. Piaskoski, M. D._____Milwaukee
P. J. Collopy, M. D._____Milwaukee
E. P. Roemer, M. D._____Madison
J. G. Beck, M. D._____Sturgeon Bay
C. C. Gascoigne, M. D._____Kohler

## AWARD FOR OUTSTANDING RESEARCH IN THE FIELD OF INFERTILITY

The American Society for the Study of Sterility announces the opening of the 1954 contest for the most outstanding contribution to the subject of infertility and sterility. The winner will receive a cash award of $1,000, and the essay will appear on the program of the 1954 meeting of the society. Essays submitted in this competition must be received not later than March 1, 1954. For full particulars concerning requirements of this competition, address The American Society for the Study of Sterility, c/o Dr. Herbert H. Thomas, Secretary, 920 South 19th Street, Birmingham, Alabama.

The author should append on a separate sheet of paper a short biographical sketch of himself and include a photograph to be used in the necessary publicity should he be the winner of the award.

# Charter Law of Medical Societies in Wisconsin

## Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

(3) (a) The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(b) Such plan shall be exempt from the state insurance laws except those provisions relating to nondiscriminatory rates contained in section 201.53, investments contained in section 201.25 and premium reserves contained in section 201.18 (1).

(c) The society shall file with the commissioner of insurance a written declaration defining the organization and structure of the proposed sickness care plan and its area of operations and shall file any amendments or changes thereto. There shall also be filed with the commissioner specimen copies of all contracts with the insured and with the participating physicians and surgeons and the form of such contracts must be approved by the commissioner.

(d) The provisions of section 148.01 (3) (c) shall not apply to any plan nor to any revisions thereof in existence on the effective date of this paragraph, nor to any contracts for the care of the indigent, nor shall any provision of chapter 148 be construed to apply to any corporation, association or organization not a body corporate under said chapter.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

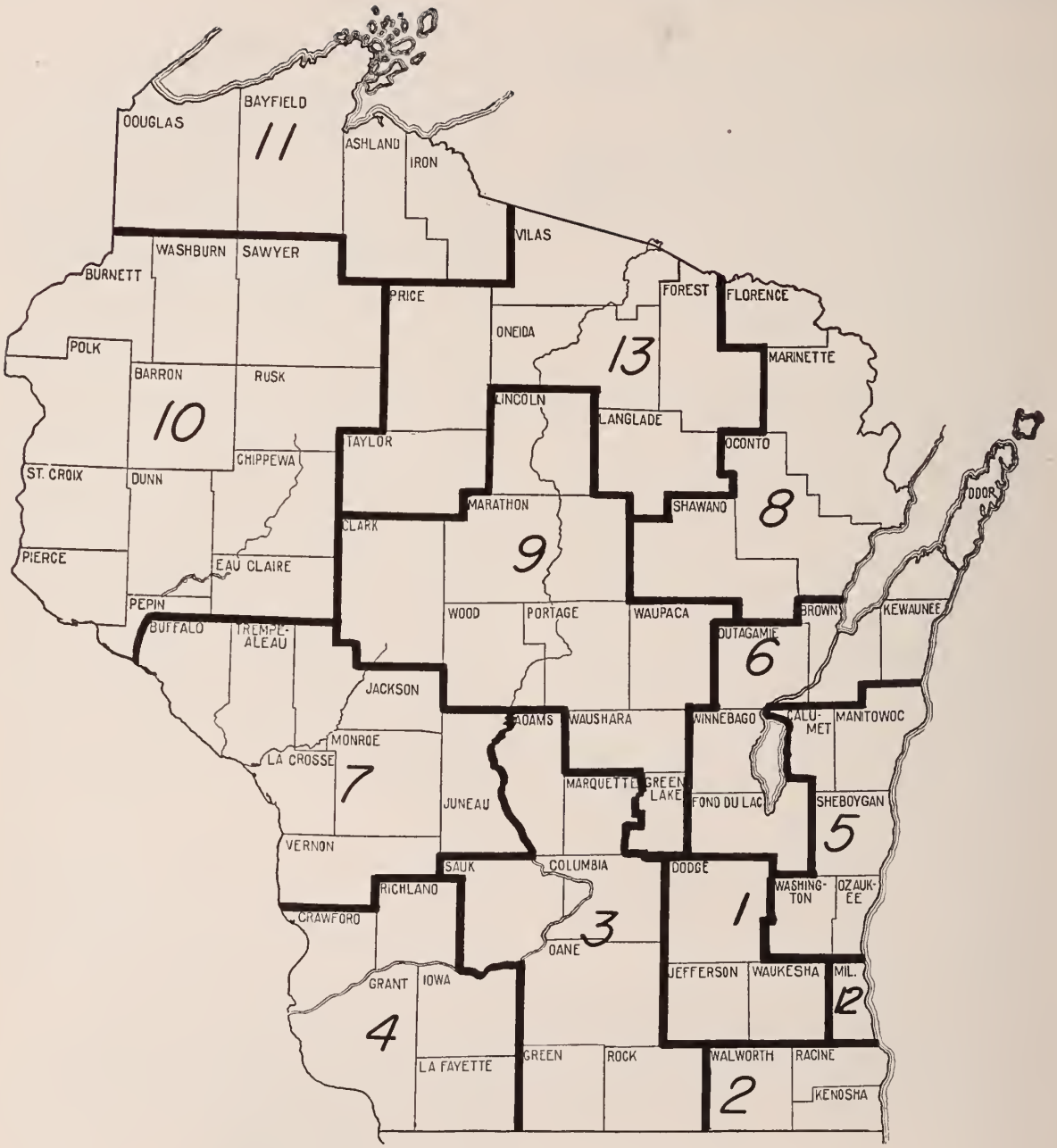
(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

## 1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.




## MAP INDICATING LOCATION OF COUNCILOR DISTRICTS

**First District:**
Dr. W. H. Costello, Beaver Dam

**Second District:**
Dr. T. C. Hemmingsen, Racine

**Third District:**
Dr. N. A. Hill, Madison
Dr. H. E. Kasten, Beloit

**Fourth District:**
Dr. E. M. Dessloch, Prairie du Chien

**Fifth District:**
Dr. A. H. Heidner, West Bend

**Sixth District:**
Dr. A. J. McCarey, Green Bay

**Seventh District:**
Dr. J. C. Fox, La Crosse

**Eighth District:**
Dr. J. M. Bell, Marinette

**Ninth District:**
Dr. R. E. Garrison, Wisconsin Rapids

**Tenth District:**
Dr. R. G. Arveson, Chairman, Frederic

**Eleventh District:**
Dr. V. E. Ekblad, Superior

**Twelfth District:**
Dr. R. E. Galasinski, Milwaukee
Dr. E. L. Bernhart, Milwaukee
Dr. N. J. Wegmann, Milwaukee
Dr. W. T. Casper, Milwaukee

**Thirteenth District:**
Dr. C. E. Zellmer, Antigo

Dr. S. E. Gavin, Chairman Emeritus, Fond du Lac

# The State Medical Society of Wisconsin

## 1954 · Officers and Councilors

**President**

Dr. H. Kent Tenney
1 South Pinckney
Madison

**President–Elect**

Dr. A. J. McCarey
305 East Walnut Street
Green Bay

**Secretary**

Mr. C. H. Crownhart
704 East Gorham Street
Madison 3

**Assistant Secretary**

Mr. Roy T. Ragatz
704 East Gorham Street
Madison 3

**Treasurer**

Dr. F. L. Weston
1 South Pinckney
Madison

**Speaker, House of Delegates**

Dr. L. O. Simenstad
Osceola

**Councilors***

(Dr. R. G. Arveson, Frederic, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. W. H. Costello, Beaver Dam, 1954.

Second: Kenosha, Racine and Walworth County Societies. Dr. T. C. Hemmingsen, 1332 State Street, Racine, 1954.

Third: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies, Dr. N. A. Hill, 304 West Washington Avenue, Madison 1955; Dr. H. E. Kasten, 419 Pleasant Street, Beloit, 1954.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. E. M. Dessloch, Prairie du Chien, 1955.

Fifth: Calumet, Manitowoc, Sheboygan and Washington–Ozaukee County Societies. Dr. A. H. Heidner, West Bend, 1955.

Sixth: Brown–Kewaunee–Door, Fond du Lac, Outagamie and Winnebago County Societies. Dr. A. J. McCarey, 305 East Walnut Street, Green Bay, 1955.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. Dr. J. C. Fox, 508 Batavia Bank Building, La Crosse, 1956.

Eighth: Marinette–Florence, Oconto and Shawano County Societies. Dr. J. M. Bell, Marinette, 1956.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. Dr. R. E. Garrison, Wisconsin Rapids, 1956.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson (chairman) Frederic, 1956.

Eleventh: Ashland–Bayfield–Iron and Douglas County Societies. Dr. V. E. Ekblad, 1507 Tower Avenue, Superior, 1954.

Twelfth: The Medical Society of Milwaukee County. Dr. R. E. Galasinski, 1227 West Lincoln Avenue, Milwaukee; Dr. E. L. Bernhart, 2714 West Burleigh Street, Milwaukee; Dr. N. J. Wegmann, 2510 West Capitol Drive, Milwaukee, 1954; Dr. W. T. Casper, 2218 North Third Street, Milwaukee, 1955.

Thirteenth: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Dr. C. E. Zellmer, Antigo, 1956.

Dr. J. C. Griffith, 944 North Jackson Street, Milwaukee.

Dr. S. E. Gavin, 104 South Main Street, Fond du Lac, Chairman Emeritus.

**Delegates to American Medical Association**

Dr. S. E. Gavin (1954)
104 South Main Street
Fond du Lac

Dr. W. D. Stovall (1955)
State Laboratory of Hygiene
Madison

Dr. D. H. Witte (1954)
3300 West Wisconsin Avenue
Milwaukee

**Alternates**

Dr. L. O. Simenstad (1954)
Osceola

Dr. Joseph C. Griffith (1954)
944 North Jackson Street
Milwaukee

Dr. G. E. Forkin (1955)
Menasha

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* Map indicating location of councilor districts, page 110.

# Standing Committees—1953-1954

*Committee on Cancer*

R. P. Welbourne, M.D., chairman, 1954, 113 North Third Street, Watertown

A. R. Curreri, M.D., 1955, 1300 University Avenue, Madison

W. S. Bump, M.D., 1956, 1020 Kabel Avenue, Rhinelander

James E. Conley, M.D., 1956, 425 East Wisconsin Avenue, Milwaukee

J. W. Conklin, M.D., 1956, Platteville

A. C. Taylor, M.D., 1954, 103 West College Avenue, Appleton

P. B. Blanchard, M.D., 1954, Cedarburg

W. E. Bargholtz, M.D., 1954, 522 West Second Street, Ashland

K. G. Pinegar, M.D., 1955, 1723 Main Street, Marinette

R. B. Larsen, M.D., 1955, 510 Third Street, Wausau

G. I. Uhrich, M.D., 1956, 319 Main Street, La Crosse

Lucille Radke, M.D., 1956, 307 East La Salle Avenue, Barron

R. J. Schacht, M.D., 1956, 1704 Milwaukee Avenue, Racine

*Committee on Grievances*

R. E. Fitzgerald, M.D., 1954, chairman, 2218 North Third Street, Milwaukee 12

E. W. Mason, M.D., 1956, 324 East Wisconsin Avenue, Milwaukee 2

E. D. Sorenson, M.D., 1956, Elkhorn

C. E. Zellmer, M.D., 1954, Antigo

F. A. Nause, M.D., 1955, 927–A North Eighth Street, Sheboygan

H. W. Wirka, M.D., 1955, 1300 University Avenue, Madison

C. D. Neidhold, M.D., 1954, 103 West College Avenue, Appleton

C. B. Hatleberg, M.D., 1955, 206 Bridge Street, Chippewa Falls

J. L. Moffett, M.D., 1956, 107 East Main Street, Platteville

*Committee on Hospital Relations*

A. H. Barr, M.D., 1954, chairman, 214 North Wisconsin Street, Port Washington

S. R. Beatty, M.D., 1954, 117 North Commercial Street, Neenah

W. B. Hildebrand, M.D., 1955, 216½ Main Street, Menasha

O. V. Overton, M.D., 1955, 58 South Main Street, Janesville

W. R. Kreul, M.D., 1956, 100 Twelfth Street, Racine

R. S. Haukohl, M.D., 1956, 1821 West Wisconsin Avenue, Milwaukee

*Committee on Medical Education and Hospitals*

T. L. Squier, M.D., 1956, 425 East Wisconsin Avenue, Milwaukee 2

N. M. Clausen, M.D., 1958, 2 West Gorham Street, Madison 3

Norman Becker, M.D., 1954, 104 South Main Street, Fond du Lac

J. W. Boren, Jr., M.D., 1955, 1510 Main Street, Marinette

A. P. Zlatnik, M.D., 1957, 1421 Seventeenth Street, Two Rivers

W. S. Middleton, M.D., ex officio, 1300 University Avenue, Madison 6

J. S. Hirschboeck, M.D., ex officio, 561 North Fifteenth Street, Milwaukee 3

*Committee on Coordination of Medical Services*

J. F. Wilkinson, M.D., 1957, chairman, 114 East Wisconsin Avenue, Oconomowoc

W. H. Costello M.D., 1954, Beaver Dam

T. W. Tormey, M.D., 1955, 16 North Carroll Street, Madison 3

S. E. Gavin, M.D., 1956, 104 South Main Street, Fond du Lac

R. B. Larsen, M.D., 1958, 510 Third Street, Wausau

President, ex officio

Secretary, ex officio

*Council on Medical Services*

D. E. Dorchester, M.D., 1954, chairman, 10 North Third Avenue, Sturgeon Bay

T. D. Elbe, M.D., 1956, Thiensville

J. F. Maser, M.D., 1956, Rice Lake

D. N. Goldstein, M.D., 1956, 625 Fifty-Seventh Street, Kenosha

R. L. MacCornack, M.D., 1954, Whitehall

C. G. Reznichek, M.D., 1954, 2037 Winnebago Street, Madison 4

D. M. Willison, M.D., 1955, 314 East Grand Avenue, Eau Claire

J. S. Devitt, M.D., 1955, 944 North Jackson Street, Milwaukee 2

W. J. Fencil, M.D., 1955, The Monroe Clinic, Monroe

*Committee on Public Policy*

J. M. Sullivan, M.D., 1957, chairman, 161 West Wisconsin Avenue, Milwaukee

J. R. Schroder, M.D., 1958, 500 West Milwaukee Street, Janesville

J. A. Enright, M.D., 1954, 720 North Jefferson Street, Milwaukee 2

S. E. Gavin, M.D., 1955, 104 South Main Street, Fond du Lac

J. K. Curtis, M.D., 1956, 2500 Overlook Terrace, Madison

President, ex officio

President-elect, ex officio

Secretary, ex officio

*Council on Scientific Work*

J. W. Gale, M.D., 1954, chairman, 1300 University Avenue, Madison 6

P. A. Midelfart, M.D., 1955, 314 East Grand Avenue, Eau Claire

S. A. Morton, M.D., 1956, 3321 North Maryland Avenue, Milwaukee 11

M. G. Rice, M.D., 1957, 401 Main Street, Stevens Point

L. G. Kindschi, M.D., 1958, The Monroe Clinic, Monroe

R. S. Baldwin, M.D., ex officio, 650 South Central Avenue, Marshfield

J. S. Hirschboeck, M.D., ex officio, 561 North Fifteenth Street, Milwaukee 3

W. S. Middleton, M.D., ex officio, 1300 University Avenue, Madison 6

## Council Committees

The following committees are committees of the Council. Appointments are made by the chairman of the Council following its annual meeting in February, and names of committee members are published in the March issue of the *Journal.*

Advertising
Audit and Budget
Blood Bank
Civil Defense
Commission on Prepaid Plans
Commission on State Departments
Editorial Board
Interim Committee
Military Medical Service
Veterans Medical Service Agency

## UNIVERSITY OF MINNESOTA TO PRESENT COURSE IN EMERGENCY SURGERY

The University of Minnesota announces a continuation course in Emergency Surgery for General Physicians which will be presented at the Center for Continuation Study April 1 to 3, 1954. The course will stress the emergency management of various types of trauma and of acute abdominal conditions. The faculty for the course will include Dr. J. Garrott Allen, Professor of Surgery, The University of Chicago School of Medicine, who will also deliver the annual Clarence M. Jackson Lecture on the evening of April 1. The program will be presented under the direction of Dr. O. H. Wangensteen, Professor and Chairman, Department of Surgery; and clinical and full-time members of the staff of the University of Minnesota Medical School will complete the faculty.

# Members, State Medical Society of Wisconsin*

**Adams:**
Ingersoll, B. P.
Ingersoll, R. S.

**Adell:**
Bemis, I. M.
Naylen, F. J.

**Albany:**
Bongiorno, F. J.

**Algoma:**
March, J. F.
Pudleiner, H. G.
Stiehl, C. W.

**Allenton:**
Fisher, R. S.

**Alma:**
Bachhuber, M. O.

**Amery:**
Cornwall, W. B.
Dasler, H. A.
Ford, K. K.
Kremser, V. C.
Marra, M. G.
Whitlark, F. L.

**Amherst:**
Osicka, S. R.

**Antigo:**
Bloor, E. G.
Curran, W. P.
Donohue, M. J.
Dorzeski, E. F.
Garbisch, F. H.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.
Thomas, W. C.
Zellmer, C. E.

**Appleton:**
Adrians, W. A.
Aldridge, C. W., Jr.
Benton, J. L.
Bolton, E. L.
Buffmire, D. K.
Carlson, G. W.
Cunningham, P. M.
Dafoe, W. A.
DeCock, R. D.
Dehne, W. O.
Felton, W. C.
Frawley, W. J.
French, G. A.
Gallaher, D. M.
Giffin, W. S.
Gmeiner, J. E.
Gross, H. T.
Hale, William H.
Harrington, Wm. J.
Hauch, F. M.
Hegner, G. T.
Huberty, F. J.
Kagen, M. S.
Konz, S. A.
Krueger, E. N.
Laird, J. W.
Landis, R. V.
MacLaren, J. B.
Marshall, F. S.
Marshall, V. F.
McBain, L. B.
Mielke, E. F.
Neidhold, C. D.
Rankin, F. J.
Siegrist, K. J.
Simenson, R. S.
Skibba, J. P.
Swanton, M. E.
Talbot, A. E.
Taylor, A. C.
Williams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.

**Arcadia:**
Comstock, Elizabeth
Dockendorff, B. C.
Weber, F. T.

**Argyle:**
Thompson, L. L.

**Arpin:**
Ryan, C. J.

**Ashland:**
Andrus, A. D.
Bargholtz, W. E.
Butler, Albert
Grand, C. A.
Grigsby, R. O.
Harrison, G. W.
Jauquet, J. M.
Kreher, J. E.
Merrill, W. G.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Smiles, C. J.
Smiles, W. J.
Tucker, W. J.
Weeks, F. D.

**Athens:**
Bachhuber, G. J.

**Avoca:**
Reynolds, Bertha

**Augusta:**
Emanuel, D. E.
Moland, O. G.
Thieda, E. S.

**Bailey's Harbor**
Fillbach, H. E.

**Baldwin:**
Olson, C. A.
Sargeant, G. M.

**Balsam Lake:**
Burdette, Stella I.

**Bangor:**
Ruppenthal, K. P.

**Barahoo:**
Edwards, A. C.
Hannan, K. D. L.
Huth, M. F.
McGonigle, B. E.
Moon, J. F.
Pearson, C. R.
Tryon, F. E.

**Barron:**
Fostvedt, G. A.
Guy, J. R.
Radke, Lucille M.
Strang, C. J.
Templeton, H. M.

**Bayfield:**
Moody, L. W.

**Bear Creek:**
Morneau, L. F.

**Beaver Dam:**
Bayley, H. G.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Corso, Xavier
Costello, W. H.
Drescher, G. G.
Foley, M. E.
Hoyer, A. A.
Hoyer, E. C.
Kores, A. B.
Qualls, C. L.
Roberts, R. R.
Rosenheimer, A. M.
Vrabec, A. P.
Way, R. W.
Webb, E. P.
Welsch, J. M.

**Belgium:**
Dorr, R. H.

**Belleville:**
Donlin, W. F.

**Belmont:**
Turgeson, J. F.

**Beloit:**
Allen, W. J.
Baldwin, R. M.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Cauldwell, E. W.
Clark, D. M.
Cochrane, W. L.
Crockett, W. W.
Crone, V. D.
Fitzgerald, W. M.
Flarity, T. H.
Fosse, Benjamin
Friend, L. J.
Glesne, O. G.
Gunderson, R. H.
Helm, H. M.
John, G. W.
Johnson, F. K.
Jones, E. T.
Kasten, H. E.
Kishpaugh, H. W.
Mauermann, W. J.
McGaughey, C. G.
Ottow, A. F.
Peterson, G. H.
Pollard, W. H., Jr.
Raube, H. A.
Rechlitz, E. T.
Sanderson, R. J.
Shearer, H. A.
Springberg, J. C.
Thayer, R. A.
Thomson, G. H.
Twyman, A. H.
Vivian, R. S.
Wilson, R. F.

**Berlin:**
Koch, H. C.
Seward, L. J.
Sievers, D. J.
Stone, G. C.
Taugher, V. J.
Wiesender, A. J.

**Big Bend:**
Boldt, R. E.

**Birnamwood:**
Damp, O. E.

**Black River Falls:**
Krohn, Robert
Marks, J. R.
Peterson, D. R.

**Blair:**
Schneider, O. M.

**Blanchardville:**
Unterholzner, L. J.

**Bloomer:**
Clauson, C. T.
Hudek, D. F.
Murphy, P. W.

**Bloomington:**
Brooks, E. H.
Cusick, W. S.
Edwards, P. K.

**Bonduel:**
Terlinden, J. H.

**Boscobel:**
Freymiller, E. F.
Hayman, C. S.
McNamee, J. R.
Randall, E. M.
Randall, M. W.

**Brandon:**
Lautenbach, E. T.

**Brillion:**
Guthrie, J. M.
Langmack, W. A.

**Brodhead:**
Stovall, W. D., Jr.
Stuessy, M. W.

**Brownsville:**
Friedrich, L. E.
Raymond, R. G.
Ries, M. F.

**Bruce:**
Whalen, M. L.

**Burlington:**
Baker, D. J.
Bennett, J. F.
Carroll, J. H.
Erickson, L. W.
Granzeau, H. W.
Mastalir, L. O.
Newell, F. F.
Sroka, Wm. C.
Van Liere, J. D.

**Butler:**
Schoeneman, R. H.

**Cadott:**
Haines, B. J.
Zenner, C. E.

**Cambria:**
Pavelsek, J. W.

**Cambridge:**
Amundson, K. K.
Bilstad, G. E.

**Cameron:**
Cronk, C. F.

**Campbellsport:**
Guenther, O. F.
Hoffmann, L. A.

**Casco:**
Kerscher, E. J.

**Cashton:**
Mauel, N. M.

**Cassville:**
David, J. J.

**Cedarburg:**
Blanchard, P. B.
Hurth, O. W.
Katz, H. J.

**Cedar Grove:**
Jensen, J. S.
Voskuil, Anthony

**Chaseburg:**
Richter, J. R.

**Chetek:**
Adams, R. W.
Balken, J. B.
Hammond, D. F.

**Chilton:**
Goggins, J. W.
Humke, E. W.
Humke, K. R.
Knauf, N. J.
Minahan, J. J.
Rathert, E. T.

**Chippewa Falls:**
Brown, F. J.
Graber, R. E.
Hatleberg, C. B.
Hatleberg, E. J.
Henske, W. C.
Janc, W. F.
Kelly, J. A.
Kemper, C. A.
McHugh, F. T.
Picotte, L. W.
Sazama, F. B.
Sazama, J. J.
Williams, S. E.

* As of December 15, 1953

**Clear Lake:**
Campbell, L. A., Jr.

**Cleveland:**
Feider, A. P.

**Clinton:**
Thomas, W. O.

**Clintonville:**
Arnold, W. G.
Auld, Irving
Bate, L. C.
Bolinske, R. E.
German, J. D.
Larson, Owen E.
Miller, E. A.
Mulvaney, J. J.
Topp, C. A.

**Cochrane:**
Meili, E. A.

**Colby:**
Christofferson, H. H.
Koch, James W.

**Coleman:**
Graner, L. H.

**Colfax:**
Cooper, C. A.
Felland, O. M.

**Columbus:**
Caldwell, H. M.
Cheli, C. F.
Mudroch, J. A.
Poser, E. M.
Poser, J. F.
Poser, R. F.

**Cornell:**
Rahn, B. F.

**Crandon:**
Moffet, D. V.
Rathert, Burton S.

**Cross Plains:**
Froggatt, W. E. L.
Lappley, W. F.

**Cuba City:**
King, C. S.
Terry, R. E.

**Cudahy:**
Ackerman, D. S.
Ackerman, E. J.
Fine, J. M.
Kash, S. H.
Landsberg, Manfred
Partridge, C. D.

**Cumberland:**
Houlton, Wm. H.
Lund, R. E.
Lund, S. O.
Thompson, R. C.

**Darien:**
Truex, G. O.

**Darlington:**
McConnell, E. D.
McGreane, N. A.
Oertley, Robert E.
Olson, Lyle L.

**Deerfield:**
Ingwell, C. L.

**De Forest:**
Grinde, J. M.

**Delafield:**
Olsen, L. C. J.

**Delavan:**
Crowe, N. F.
Galgano, R. S.
Jacobson, T. L.
Levin, H. M.
Martin, J. E., Jr.
Moses, R. A.
O'Keefe, F. L.
Werbel, H. J.
Woods, Wm. C.

**Denmark:**
Bergwall, W. L.
Hering, G. V.
Michna, C. T.

**De Pere:**
Elders, W. F.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

**De Soto:**
Bolstad, H. A.

**Dodgeville:**
Hamilton, W. P.
Hamlin, W. D.
Morton, H. H.
Walker, H. M.

**Dorchester:**
Foley, F. P.

**Dousman:**
Notbohm, W. R.
Watry, T. D.

**Durand:**
Blose, Irvin L.
Bryant, R. J.

**Eagle River:**
Burnett, C. H.
Colgan, J. J.
Oldfield, R. A. A.

**East Ellsworth:**
Klaas, F. B.

**East Troy:**
Kohn, Louis

**Eau Claire:**
Aitken, H. M.
Anderson, F. G.
Beebe, G. W.
Blom, Julius
Brown, Richard C.
Buckley, R. A.
Cameron, W. G.
Dasler, T. W.
Derge, H. F.
Durham, R. A.
Falstad, C. H.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
German, K. L.
Haag, A. F.
Hayes, E. P.
Henke, S. L.
Hilker, A. W.
Huston, H. C.
Ihle, C. M.
Kennedy, R. L.
Kinsman, F. C.
Klein, A. J.
Lorenz, A. A.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Mason, E. L.
Mautz, W. T.
McAffee, G. D.
Midelfart, Peter
Nester, H. D.
Nezworski, L. G.
Parrish, J. G., Jr.
Paulson, W. O
Richards, R. R.
Russell, S. B.
Sorensen, H. E.
Spelbring, P. G.
Stewart, Katherine
Strand, R. C.
Tanner, J. W.
Wahl, G. E.
Walter, K. E.
Willison, D. M.
Wishart, J. H.
Ziegler, J. E. B.

**Edgar:**
Schulz, H. A.

**Edgerton:**
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Shearer, A. T.
Shearer, F. E.
Sumner, W. C.

**Elcho:**
Dailey, D. W.
Dailey, P. J.

**Elkhart Lake:**
Martineau, J. E.

**Elkhorn:**
Bill, K. C.
Hatfield, Margaret E.
Helmbrecht, M. G.
Rawlins, J. A.
Sorenson, E. D.
Young, J. H.

**Ellsworth:**
Aanes, A. R.

**Elm Grove:**
Grade, J. O.
Schmidt, E. A.
Zurheide, H. J.
Zurheide, H. J. O.

**Elmwood:**
Springer, F. A.
Springer, J. P.

**Elroy:**
Demke, R. L.

**Ettrick:**
Rogne, C. O.

**Evansville:**
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

**Fall Creek:**
Zboralske, F. F.

**Fennimore:**
Bailey, M. A.
Howell, E. C.
Shields, E. H., Jr.

**Fond du Lac:**
Becker, N. O.
Borsack, K. K.
Cerny, F. J.
Coyne, John F.
Devine, H. A.
Devine, J. C.
Flanagan, C. M.
Folsom, W. H.
Gardner, L. C.
Gavin, S. E.
Guth, H. K.
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Kief, H. J.
Leonard, C. W.
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Pallin, Josephine J.
Pawsat, E. H.
Peterson, C. R.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sharpe, J. J.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theisen, S. A.
Twohig, D. J.
Twohig, D. J., Jr.
Vetter, E. W.
Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Willson, D. D.
Wojta, W. C.
Yockey, J. C.

**Footville:**
Harvey, J. R.

**Forestville:**
Hirschboeck, J. G.

**Ft. Atkinson:**
Gruesen, F. A.
Gueldner, L. H.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Mallow, H. G. E.
Notbohm, D. R.
Russell, J. C. H.
Venning, J. R.
Young, Will

**Fountain City:**
Skemp, F. C.

**Fox Lake:**
Elliott, E. S.

**Frederic:**
Andrews, W. C.
Arveson, R. G.
Fischer, W. A.
Moore, R. M.

**Fremont:**
Arnoldussen, C. P.

**Friendship:**
Treadwell, G. F.

**Galesville:**
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

**Gays Mills:**
Boyce, S. R.
Schott, O. J.

**Genoa City:**
McNeel, Laird

**Gillett:**
Bailey, D. M.

**Gilman:**
McLane, Wm. L.

**Glenwood City:**
Limberg, A. W.
Limberg, P. W.
McCusker, C. F.

**Glidden:**
Ansfield, F. J.

**Gordon:**
Lorenz, Wm. F.

**Grafton:**
Pelant, K. F.

**Green Bay:**
Atkinson, H. S.
Boersma, J. J.
Bolles, C. S.
Breckenridge, H. E.
Brusky, A. H.
Brusky, E. S.
Burdon, T. S.
Charbonneau, A. A.
Clark, E. V., Jr.
Cowles, R. L.
Daley, E. F.
Danaher, H. H.
Denys, G. F.
Denys, K. J.
Dettmann, J. E.
Dockry, P. F.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Fuller, M. H.
Goelz, J. R.
Gosin, D. F.
Gosin, F. J.
Gosin, Robert F.
Griggs, S. L.
Grossman, M. A.
Hagerty, W. T.
Halloin, J. E.
Heitzman, H. H.
Hipps, C. J.
Hitch, O. M.
Icks, K. R.
Jordan, E. M.
Kane, Elizabeth D.

Kaufman, J. E.
Killeen, E. R
Killins, J. A.
Killins, W. A.
Kispert, R. W
Klobucar, J. J.
Kuehl, F. O.
Kuhs, M. L.
Kulkoski, Bernard
Leaper, W. E.
Levitas, I. E.
McCarey, A. J.
McDermott, J. F.
Miller, L. C.
Milson, Louis
Mokrohisky, S. M.
Nadeau, E. G.
Nadeau, E. George, Jr.
Nellen, J. W.
Neu, V. F.
Paine, E. M.
Quigley, L. D.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Saunders, O. W.
Schmidt, E. S.
Schmidt, R. T.
Shinners, G. M.
Stauff, G. R.
Stiennon, O. A.
Sullivan, Donel
Tippet, W. P.
Troup, R. L.
Troup, W. J.
Urban, Frank
Wunsch, C. A.

**Green Lake:**
Leininger, A. T.

**Greendale:**
Brown, R. J.
Curtin, J. J.

**Greenwood:**
Olson, W. A.

**Gresham:**
Litzen, F. L.

**Hales Corners:**
Buhl, John L.
Larsen, L. L.
Pierce, D. F.
Wolf, R. C.

**Hartford:**
Hoffmann, J. G
Hoffmann, W. C. P.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. O.
Quandt, V. V.
Sachse, F. W.

**Hartland:**
Bergwall, R. P.
Hansen, R. T.
Ridley, J. F.

**Hayward:**
Callaghan, D. H.
Krueger, E. R.
Wyant, M. E.

**Hazel Green:**
Rosmann, H. K.
Strauch, C. B.

**Highland:**
Erickson, M. T.

**Hilbert:**
Winkler, R. J.

**Hillsboro:**
Leuther, P. A.
Sanford, L. L.

**Hollandale:**
Marshall, S. B.

**Horicon:**
Karsten, J. H.
Knudson, R. A.

**Hortonville:**
Flanagan, F. J.
Towne, W. H.

**Hudson:**
Anderson, M. G.
Bourget, G. E.
Hopkins, G. J.
Livingstone, J. W.
Newton, J. E.
Nuebel, C. J.

**Hurley:**
Bonacci, M. J.
Martinetti, D. J.

**Hustisford:**
Goetsch, O. F.

**Independence:**
Cinelis, Ann A.

**Iola:**
Wiley, R. H.

**Jackson:**
Albrecht, J. E.
Evans, H. C.

**Janesville:**
Bartels, G. W.
Baumgartner, M. M.
Betlach, Dorothy W.
Betlach, Eugene H.
Chasten, S. M.
Clark, W. T.
Danforth, H. C.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gredler, Gerald P.
Gutmann, G. E.
Hartlaub, E. S.
Johnson, W. L.
Kelley, J. F.
Klein, T. W.
Koch, V. W.
Llewellyn, M. B.
McGuire, W. H.
Metcalf, G. S.
Nuzum, T. O.
Odland, P. K.
Overton, O. V.
Overton, R. S.
Pember, A. H.
Pember, J. F.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Schroder, John R.
Schroeder, Jack D.
Snodgrass, H. M.
Snodgrass, T. J.
Steinkopff, E. K.
Tarrasch, Hertha
Thomas, G. L.
Tomlinson, Carol
Tordoff, J. J.
Welch, F. B.

**Jefferson:**
Brewer, J. C.
Busse, A. A.
Caswell, H. O.
Garding, C. J.
Quandt, C. E.
Quandt, R. W.
Robinson, A. H.

**Johnson Creek:**
Wendt, F. A.

**Junction City:**
Reis, G. W.

**Juneau:**
Heath, H. J.

**Kaukauna:**
Bachhuber, A. E.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Flanagan, G. J.
Russo, J. G.

**Kenosha:**
Ambro, P. J.
Andre, E. F.
Ashley, R. W.
Ashley, T. W.
Bertolaet, E. E.
Binnie, Helen A.
Bjork, H. A.
Block, R. M.
Bode, M. J.
Bonell, B. T.
Braun, W. E.
Creighton, L. H
Creswell, C. M.
Davin, C. C.
DeFazio, S. F.
Duncan, J. T., Jr.
Garren, J. T.
Goldstein, D. N.
Graves, J. P.
Hill, B. Spaulding
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Kordecki, F. A.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Morrow, C. A.
Olsman, Louis
Pearson, J. B.
Pechous, C. E.
Pechous, Lillian
Pirsch, Margaret V.
Randall, A. J.
Rauch, A. M.
Rauen, L. M.
Richards, C. G.
Richards, J. N.
Rufflo, A. F.
Sattler, C. A.
Schlapik, Alexander
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Slegel, Morris
Stewart, W. C.
Swift, W. J.
Turner, Lewis III
Ulrich, C. F.
Welsch, R. G.
Williams, F. C., Jr.

**Kewaskum:**
Edwards, R. G.

**Kewaunee:**
Nesemann, R. M.
Witcpalek, E. W.
Witcpalek, W. W.

**Kiel:**
Nauth, D. F.
Twohig, G. J.

**Kimberly:**
Curtin, D. W.
Gage, Ralph S.

**King:**
Hathaway, G. J.
Montgomery, R. C.

**Kohler:**
Gascoigne, C. C.
Rowe, D. M.

**La Crosse:**
Bach, A. C.
Bruder, V. F. J.
Buchman, D. M.
Carlsson, E. S.
Cook, A. A.
Daley, D. M.
Davies, May A.
Dietz, P. C.
Douglas, F. A.
Doyle, D. F.
Egan, G. J., Jr.
Egan, J. F.
Ernst, F. W.
Flynn, R. E.
Fox, J. C.
Gallagher, E. E.
Gallagher, F. J.
Gatterdam, P. C
Ghormley, Kenneth O.
Gilbert, R. L.
Gorenstein, L. M.
Gray, R. H.
Gundersen, A. H.
Gundersen, Gunnar
Gundersen, S. B.
Gundersen, T. E.
Gustafson, Everette
Harman, J. C.
Heraty, J. E.
Hickey, A. W.
Himmelsbach, W. A.
Hulick, P. V.
Jaeck, James L.
Jones, W. J.
Mansheim, B. J.
McCann, John P.
McGarty, M. A.
McMahon, R. E.
McNamara, T. B.
Midelfort, C. F.
O'Meara, M. T.
Pauly, James P.
Perry, E. L.
Ramlow, R. W.
Rasmus, R. B.
Reay, G. R.
Ridout, G. B.
Rutter, Thomas
Satory, J. J.
Schaefer, Margaret A.
Schmidt, L. R.
Schneeberger, E. J.
Sevenants, J. J.
Simones, J. J.
Sivertson, Martin
Skemp, A. A.
Skemp, G. E.
Skemp, J. T.
Smith, D. S.
Swarthout, Edyth C.
Uhrich, G. I.
Wolf, F. H.

**Ladysmith:**
Bauer, W. B. A. J.
Bennett, R. P.
Lundmark, L. M.
Murphy, J. E.
Pagel, H. F.
Smith, Woodruff

**La Farge:**
Gollin, F. F.

**Lake Geneva:**
Bischof, H. F.
Brady, C. J.
Hudson, E. D.
Jeffers, D. H.
Jeffers, D. H., Jr.

**Lake Mills:**
Eck, G. E.
Netzow, E. J.
Peterson, M. G.
Schoenecker, E. A.
Turcott, R. A.

**Lancaster:**
Bauman, K. L
Becher, L. E.
Carey, H. W.
Houghton, E. M.
Jackson, R. D.
Kraut, Elgie

**Land O'Lakes:**
Eickhoff, E. C.

**Laona:**
Castaldo, E. F.
Ovitz, E. G.

**Lena:**
Rose, J. F.

**Little Chute:**
Gloss, Albert J.
Verbrick, W. C.

**Lodi:**
Groves, R. J.
Irwin, W. G.

**Loganville:**
Jewell, E. L.

**Lomira:**
Fuller, J. D.

**Loyal:**
Hable, A. P.

**Luxemburg:**
Majeski, H. H.

**Madison:**
Aageson, C. W
Albright, E. C.
Allin, R. N.
Anderson, A. D.
Anderson, R. B.
Angevine, D. M.
Ashman, H. C.
Atwood, D. C.
Bardeen, Ann
Becker, R. M.
Bell, P. P.
Benish, G. A.
Bennett, Maxine
Bentley, J. E.
Berger, J. V., Jr.
Berglund, George A.
Bernard, F. D.
Beyer, John A.
Bleckwenn, W. J.
Boner, A. J.
Brindley, B. I.
Britton, D. M.
Brown, F. A.
Brown, J. W.
Bryan, A. W.
Buesseler, John A.
Burke, C. F.
Burke, Mead
Burke, Myra E.
Burns, E. M.
Burns, R. E.
Calvert, Charlotte
Campbell, R. E.
Canfield, Albert
Carns, Marie L.
Carter, H. M.
Chase, S. L.
Clausen, N. M.
Collins, R. F.
Cooksey, R. T
Coon, H. M.
Cooper, G. A
Cortner, J. W.
Crawford, C. W.
Crepea, Seymour R.
Crowley, W. P., Jr.
Crumpton, C. W.
Curreri, A. R.
Curtis, J. K.
Davis, A. W.
Davis, F. A.
Davis, F. J.
Davis, Milton, Jr.
Dean, F. K.
Dean, J. C.
Dean, J. L.
Dean, J. P.
Deiss, W. P., Jr.
Derus, Gerald J.
Dickie, Helen A.
Dieter, D. G.
Dimond, W. B.
Dollard, J. E
Domine, A. Z.
Doolittle, J. W.
Dornette, W. H.
Duehr, P. A.
Erickson, T. C.
Ewell, G. H
Farrell, R. X.
Fauerbach, Louis
Feig, Milton
Filek, A. A.
Fitch, Edna M.
Flinn, John H.
Foe, Richard B.
Foseid, Oscar F.
Fosmark, C. A.
Foster, M. A.
Foster, Ruth C.
Fromm, A. H.
Gale, J. W.
Ganser, W. J.
Garnett, G. M.
Gearhart, R. S.
Geppert, T. V.
Glover, B. H.
Golden, F. F.
Golden, P. B.
Gonce, J. E.
Gordon, E. S.
Greene, H. L.
Grumke, E. H.
Guilford, H. M
Hamel, Merle O.
Hank, G. C.
Harmon, Doralea R.
Harper, C. S.
Harper, S. B.
Harris, J. W.
Healy, W. G.
Hennen, R. J.
Hibma, O. V.
Hill, N. A.
Hodgson, E. R.
Hoff, A. D.
Hogan, L. H.
Holmgren, L. E.
Hopkins, C. E.
Hummer, F. L.
Hunter, Amy Louise
Hurlbut, J. A.
Huston, John H.
Iams, A. M.
Jackson, A. S.
Jackson, R. H.
Jaeschke, W. H.
Joachim, F. G.
Johnson, F. C.
Johnson, S. A. M.
Jorris, E. H.
Juster, E. M.
Kant, Fritz
Kay, H. M.
Kilpatrick, Leslie G.
Kincaid, C. K.
Korst, D. R.
Krehl, W. H.
Kuehn, Eleanor V.
Kundert, P. R.
Kurtz, C. M.
Kurtz, Esther C.
Lacke, C. L.
Land, J. F.
Larkin, C. B.
Larson, F. C.
Lawrence, P. J.
Lee, James M.
Lemmer, K. E.
Leonard, T. A.
Lewis, W. C.
Liebl, E. R.
Lindsay, W. T.
Littig, L. V.
Lorenz, T. H.
Lubing, H. N.
Ludden, R. H.
Luetke, W. V.
Lyons, Robert P.
Mahaffey, H. W.
Mailer, A. R.
Malec, J. P.
Maloney, F. G.
Maloof, G. J.
Marlow, Gordon V.
Marsden, W. H.
Masten, Mabel G.
McClung, John L.
McCormick, S. A.
McDermott, John P.
McDonough, K. B.
McGary, Lester
McIllece, Patricia E.
McIntosh, R. L.
McMurray, Ora R.
Mehnert, J. H.
Meisekothen, W. E.
Mendenhall, J. T.
Meyer, O. O.
Middleton, W. S.
Miller, J. E.
Mohs, F. E.
Mueller, John J.
Musser, M. J., Jr.
Nereim, T. J.
Nesbit, M. E.
Neupert, C. N.
Newman, J. R.
Nordby, E. J.
O'Connor, Robert E.
Okagaki, H. I.
Oosterhous, G. E.
Orth, O. S.
Osborn, L. A.
Parkin, E. M.
Parkin, R. C.
Parks, H. K.
Paul, L. W.
Peters, H. A.
Peterson, D. A.
Piper, P. G.
Pohle, E. A.
Prouty, Margaret
Puestow, K. L.
Quisling, A. A.
Quisling, R. A.
Quisling, Sverre
Reese, H. H.
Reis, L. N.
Reznichek, C. G.
Rhoades, A. L.
Richtsmeier, A. J.
Ris, Hania W.
Roemer, E. P.
Roessler, R. L.
Rogers, S. C.
Roisum, B. H.
Round, W. M.
Salick, J. A.
Schafer, Etheldred L.
Schmidt, E. R.
Schmitz, R. C.
Schneiders, E. F.
Schoenenberger, A. P.
Schroeder, C. F.
Schubert, C. K.
Schuele, D. T.
Schwittay, Addie M.
Shapiro, H. H.
Sherman, C. F.
Shumate, J. K.
Siebecker, K. L.
Silbar, J. D.
Sims, J. L.
Sinaiko, R. P.
Sisk, I. R.
Skroch, E. E.
Smith, Max M.
Sonneland, A. M.
Soucek, Adolph
Sprague, J. T.
Sprague, L. V.
Stebbins, G. G.
Stebbins, W. W.
Steeper, J. R.
Stehr, A. C.
Stevenson, L. B.
Stiennon, O. A.
Stone, Mildred M.
Stoops, C. W.
Stovall, W. D.
Straughn, R. A.
Suckle, H. M.
Sullivan, A. G.
Supernaw, J. S.
Taborsky, C. R.
Talbot, J. R.
Tanner, W. A.
Tatum, A. L.
Taylor, F. B.
Tenney, H. K.
Tenney, H. K., III
Thornton, Madeline J.
Tormey, A. R.
Tormey, T. W.
Trautmann, Henry
Tweeten, J. K.
Urben, W. J.
van Baaren, H. J.
Van Duser, A. L.
Van Gemert, J. G.
Vingom, C. O.
Vinograd, S. P.
Waddell, J. G.
Washburne, Annette C.
Waskow, W. L.
Wasserburger, R. H.
Wear, J. B.
Weinstein, A. B.
Welke, E. G.
Werrell, W. A.
Weston, F. L.
Wheeler, R. M.
Wilkie, J. M.
Williams, D. L.
Wirig, M. H.
Wirka, H. W.
Wixson, R. C.
Worley, Gordon
Wylde, R. M.
Young, W. P.

**Manawa:**
Irvine, R. K.

**Manitowoc:**
Banker, R. J.
Belson, H. J.
Bonner, N. A.
Donohue, W. E.
Erdmann, N. C.
Gregory, L. W.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.
Lynch, J. D.
Pick, D. M.
Puestow, R. C.
Radl, C. J.
Randolph, R. C.
Rau, G. A.
Rauch, W. A.
Rees, T. H.
Scherping, W. H.
Shaw, Jesse W.
Smejkal, W. F.
Sobush, L. D.
Steckbauer, J. W.
Strong, R. G.
Stueck, A. F.
Teitgen, Arthur
Teitgen, T. A.
Thorpe, R. F.
Wall, C. E.
Yost, R. G.
Zibel, Milton

**Marathon:**
Kampine, C. E.

**Maribel:**
May, J. H.

**Marinette:**
Bell, J. M.
Boren, C. H.
Boren, Clark H.
Boren, J. W., Jr.
Duer, G. R.
Kirmse, T. W.
Koepp, C. E.
May, J. V.
McCanna, P. R.
Moss, K. J.
Nadeau, A. T.
Pinegar, K. G.
Schroeder, H. F.
Zeratsky, J. D.

**Marion:**
McInnis, W. R.
Van Schaick, R. E.

**Markesan:**
Cupery, D. P.
Pelton, R. S.

**Marshfield:**
Baldwin, Elizabeth
Baldwin, R. S.
Boeckman, F. A.
Burns, J. L., Jr.
Custer, G. S., Jr.
Dangle, Harland C.
Doege, K. H.
Doege, P. F.
Epstein, Stephan
Evenson, R. G.
Gouze, F. J.
Helland, N. J.
Lewis, R. F., Jr.
Magnin, George E.
Mason, R. W.
McCormick, G. L.
Millard, A. L.
Potter, R. P.
Rice, T. J.
Rowe, R. J.
Suits, J. J.
Vedder, C. A.
Vedder, J. S.
Wickham, J. M.
Wink, R. H.

**Mauston:**
Griffin, V. M.
Hess, J. S.
Thompson, J. E.
Vedner, J. H.

**Mayville:**
Bachhuber, F. G.
Parish, G. A.

**Mazomanie:**
Schultz, Isadore

**McFarland:**
McBride, Wm. P. L.

**Medford:**
Elvis, E. B.
Meyer, W. W.
Nystrum, L. E.
Nystrum, R. C.

**Mellen:**
Lockhart, C. W.

**Melrose:**
Lavine, I. H.

**Menasha:**
Conway, J. E.
Corry, L. F.
Forkin, G. E.
Hildebrand, G. B.
Hildebrand, W. B.
Jensen, F. G.
Jensen, R. A.
Nebel, J. R.
O'Brien, P. T.
Pratt, G. N., Jr.
Schwei, G. P.

**Menomonee Falls:**
Burkhardt, E. W.
Domann, W. G.
Schloemer, H. F.

**Menomonie:**
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Cook, F. D.
Drescher, A. A.
Gardner, Robert J.
Halgren, J. A.
Lee, S. R.
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McMahon, A. E.
O'Neill, J. W.
Quilling, P. A.
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**Merrillan:**
Schwarz, S. G.

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Kelley, F. H.
Lane, F. C.
Lewinnek, Walter
Millenbah, J. D.
Morris, K. A.
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**Milltown:**
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**Milton:**
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Crosley, G. E.
Davis, M. D.

**Milton Junction:**
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Appleby, K. B.
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Ausman, D. C.
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Babbitz, A. L.
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Babby, Louis
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Bachhuber, E. A.
Backus, E. A.
Baier, A. R.
Baker, V. L.
Baldi, J. B.
Baldigo, E. M.
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Bauch, N. G.
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Baumann, A. J.
Baumgart, C. H.
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Beckman, Harry
Beezy, Reuben
Behnke, E. J.
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Bemis, E. L.
Bender, B. I.
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Benton, R. W.
Bercey, J. E.
Bergmann, G. J.
Berner, C. L.
Bernhard, L. A.
Bernhart, E. L.
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Bickler, E. P.
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Borman, M. C.
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Bortin, M. M.
Bourne, N. W.
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Brazy, R. R.
Brewer, B. J.
Brey, P. F.
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Jurgens, G. H.
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Jurss, Charles D.
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Killian, A. D.
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King, J. J.
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Kissling, A. C., Jr.
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Kleis, W. J.
Klieger, J. A.
Kline, C. L.
Klopf, H. M.
Klumb, M. G.
Knudson, A. H.
Knutson, D. L.
Koch, M. J.
Kocovsky, E. C.
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Kohn, S. E.
Kolman, Isadore I.
Korducki, Stanley A.
Kores, Vernon E.
Kovacs, Arthur
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Krembs, M. A.
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Kretchmar, Morris
Kreuter, G. C.
Krill, Richard J.
Kristjanson, H. T.
Kritter, F. J.
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Krueger, F. J.
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Krumenacher, F. P.
Kruszewski, J. L.
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Kult, A. S.
Kurzon, Alvin M.
Kustermann, A. F.
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La Bissoniere, P. G.
Ladewig, H. C.
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Lang, V. F.
Langjahr, A. R.
Larkey, Jay A.
La Susa, T. J.
Leach, J. E.
Lee, H. J.
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Leitch, G. W.
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Leslie, C. L.
Le Tellier, Robert P.
Lettenberger, Joseph
Levin, A. J.
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Levine, Abram
Lewis, Marian
Liebman, Albert
Light, George
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Long, C. W.
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Maas, D. W.
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Malloy, T. G.
Malnekoff, B. J.
Mann, R. W
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Margoles, F. C.
Margoles, Milton
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Markson, J. W.
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Marlewski, C. R.
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Martens, E. W.
Martin, A. G.
Martineau, E. L.
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Maxwell, H. P.
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McCabe, John
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McCann, Edith F.
McCarty, R. T.
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McCormick, R. A.
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McElligott, J. A.
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Mendez, R. G.
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Waldeck, E. A.
Walker, L. J.
Walton, W. B.
Warner, R. C.
Warschauer, Bruno
Warth, C. G.
Washburn, R. G.
Watts, Alice D.
Weber, A. J.
Weber, J. E.
Weed, L. G.
Wegmann, G. H.
Wegmann, N. J.
Weil, H. R.
Weingart, W. F.
Weinshel, L. R.
Weisel, Wilson
Weisfeld, S. G.
Weisfeldt, L. A.
Weisfeldt, S. C.
Weller, R. R.
Wells, Marvin
Welsh, E. C.
Wendt, W. P.
Wepfer, J. F.
Werba, D. R.
Werner, D. J.
Werner, J. J.
Westhofen, R. C.
Wetzler, S. H.
Whalen, G. E.
Whitaker, P. J.
Wiener, Kurt
Wiese, M. E. J.
Wild, J. P.
Wilets, J. B.
Wilets, J. C.
Willson, D. M.
Winnik, D. E.
Wirthwein, C. L.
Wisniewski, P. P.
Witte, D. H.
Wolter, S. H.
Wolters, H. F.
Wong, V. J.
Wright, H. H.
Wyland, J. S.
Wyman, J. F.
Wynn, S. K.
Yaffe, Aaron
Yunck, R. E.
Zahl, W. H.
Zaun, J. J., Jr.
Zawodny, S. E.
Ziegler, C. T.
Zillmer, Helen J.
Zimmermann, B. M.
Zmyslony, W. P.
Zubatsky, D. J.

**Mineral Point:**
Hohler, E. J.
Ludden, H. D.
White, C. L.

**Minocqua:**
Huber, G. W.
Sprague, J. P.

**Mishicot:**
Skwor, C. J.

**Mondovi:**
Gillette, F. J.
Johnson, B. F.
Meyer, C. F.
Sharp, D. S.

**Monroe:**
Barry, G. R.
Baumle, C. E.
Bear, N. E.
Bear, W. G.
Blum, O. S.
Brunkow, B. H.
Eckstam, E. E.
Fencil, W. J.
Gnagi, W. B., Jr.
Irvin, J. M.
Kindschi, L. G.
Kundert, F. W.
Mings, D. E
Moore, L. A.
Olson, M. J.
Ruehlman, D. D.
Schindler, J. A.
Snowden, P. W.
Stiles, F. C.
Weir, J. R.
Witte, K. B.

**Montello:**
Inman, R. F.

**Montfort:**
Rasmussen, N. G.

**Montreal:**
Baird, H. D.
Pierpont, J. M.

**Mosinee:**
Knoedler, W. A., Jr.

**Mount Calvary:**
Miller, J. F.

**Mount Horeb:**
Buckner, H. M.
Morrison, M. T.

**Mukwonago:**
Kern, E. E.
Rath, Edward K.
Voellings, W. J.

**Muscoda:**
Ackerman, E. T.
Klockow, W. E.

**Muskego:**
Kelm, G. J.

**Neenah:**
Anderson, G. R.
Beglinger, H. F.
Brown, R. C.
Brunckhorst, F. O.
Canavan, J. P.
Graham, A. P.
Henning, Laura E.
Henning, R. E.
Kirchgeorg, Clemens
Pansch, F. N.
Petersen, G. W.
Pitz, M. N.
Quade, R. H.
Regan, D. M.
Ryan, D. J.
Smith, F. H.
Smith, Robin
Smith, T. D.
Springer, V. G.
Strauser, E. R.

**Neillsville:**
Manz, K. F.
Overman, M. V.
Rosekrans, M. C.
Rosekrans, Sarah D.

**Nekoosa:**
Jaffee, M. L.

**Neopit:**
Knauf, J. W.

**New Auburn:**
Stang, H. M.

**New Franken:**
Looze, J. A.

**New Glarus:**
Francois, S. J.
Hicks, E. V.

**New Holstein:**
Engel, A. C.
Larme, F. P.

**New Lisbon:**
Weston, C. L.

**New London:**
Borchardt, M. A.
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.

**New Richmond:**
Armstrong, J. H.
Davis, R. R.
Drury, E. M.
Epley, O. H.
Gordon, John J.
Healy, J. P.

**Niagara:**
Lamb, R. F.
Maginn, Richard J.
McCormack, E. A.

**Norwalk:**
Allen, J. S.

**Oconomowoc:**
Caffrey, James F.
Clark, O. C.
Feasler, C. H.
Grindrod, John M.
James, W. D.
Loughnan, A. J.
Matt, J. R.
Nammacher, T. H.
Peterson, F. N.
Rogers, A. F.
Stemper, Irene T.
Theobald, P. B.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, P. M.

**Oconto:**
Aageson, H. A.
Mohler, G. T.
Rogers, R. J.
Slaney, A. F.
Zantow, F. E.

**Oconto Falls:**
Rauchschwalbe, L. E.

**Ogema:**
Rinehart, B. M.

**Omro:**
Peck, D. D.
Schoenbechler, L. J.

**Onalaska:**
Reay, G. D.

**Oregon:**
Dukerschein, F. N.
Johnson, E. S.

**Orfordville:**
McNair, E. R.

**Osceola:**
Simenstad, L. O.
Weller, L. J.

**Oshkosh:**
Apell, M. G.
Beatty, S. R.
Becker, D. B., Jr.
Behnke, C. H.
Bitter, R. H.
Brei, F. A.
Clark, W. E.
Connell, F. G.
Cummings, E. F.
Danforth, Q. H.
Emrich, P. S.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Haseltine, C. P.
Haubrick, H. J
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Leibenson, S. J.
Linn, W. N.
Lockhart, J. W.
Lynch, G. V.
Mellicke, C. A.
Mell, J. V.
Meusel, H. H.
Pfefferkorn, E. B.
Romberg, H. A.
Schein, J. E.
Steele, G. A.
Steen, M. H.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.
Winter, E. F.

**Osseo:**
Knutson, Oscar
Leasum, R. N.

**Oxford:**
Nafziger, E. G.

**Palmyra:**
Handeyside, R. G.

**Pardeeville:**
Winkler, H. A.

**Park Falls:**
Leahy, J. D.
Leahy, J. J.
Murphy, J. L.

**Peshtigo:**
Haasl, H. W.

**Pewaukee:**
Egloff, L. W.
Kelly, J. P.

**Phelps:**
Schmitt, R. W.

**Phillips:**
Niebauer, W. E.
Norviel, H. B.
Rens, J. L.
Van Hecke, D. S.

**Plain:**
Allin, Thomas G., Jr.
Fowler, Paul H.

**Platteville:**
Andrew, C. H.
Bair, G. W.
Conklin, J. W.
Cunningham, Wilson
Doeringsfeld, H. L.
Moffett, J. L.
Soles, F. A.

**Plum City:**
Steiger, E. E.

**Plymouth:**
Brickbauer, A. J.
Deicher, H. F.
Evers, R. H.
Mueller, J. F.
Radloff, A. C.
Steffan, L. J.
Weisse, H. A.

**Portage:**
Harkins, J. P.
Henney, C. W.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.

**Port Edwards:**
Backus, O. A.

**Port Washington:**
Barr, A. H.
Kauth, C. P.
Savage, G. F.
Stein, C. C.
Walsh, John F.

**Pound:**
Pelkey, R. B.

**Poynette:**
Dryer, R. B.
Focke, W. J.
Stevenson, D. J.

**Prairie du Chien:**
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Satter, O. E.
Shapiro, H. L.

**Prairie du Sac:**
Trautmann, Milton
Zauft, G. F.

**Prescott:**
Laney, H. J.

**Princeton:**
Mueller, G. G.
Theiler, A. C.

**Pulaski:**
Brusky, S. F.
Shippy, V. J.

**Racine:**
Ageloff, Harry
Albino, J. M.
Bacon, G. A.
Barina, H. J.
Bennett, W. H.
Bliwas, Arnold
Brehm, H. G.
Brehm, H. J.
Buckley, W. E.
Burch, V. J.
Caton, J. R.
Christensen, F. C.
Christenson, C. W.
Constantine, C. E.
Cook, J. C.
Covell, K. W
Dockery, J. N.
Docter, J. C
Dunham, C. T.
Edwards, A. C.
Faber, S. J.
Fazen, L. E.
Fazen, L. E., Jr.
Gettelman, Sydney T.
Gillett, G. N.
Graf, A. E.
Grant, A. B.
Grinney, June L.
Grinney, L. R.
Hanson, W. C.
Hemmingsen, T. C.
Henken, J. F
Henken, W. F.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Jacobsen, A. J.
Jamieson, J. G.
Jones, Beatrice O.
Kadin, Maurice
Kehl, K. C.
Keland, H. B.
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Kurten, R. M.
Lehner, R. H.
Leitschuh, R. B.
Lifschutz, L. M.
Lindner, A. M.
Low, N. L.
MacVicar, E. L., Jr.
Madden, W. J.
Marek, F. B.
Mayer, R. J.
Miller, H. C.
Miller, W. C.
Newman, C. R.
Nickelsen, J. R.
Olson, E. S.
Petersen, J. J. G.
Peterson, R. O.
Pfeifer, E. C.
Pitts, Eugene H
Pope, F. W.
Postorino, J. D.
Rodick, J. C.
Roth, W. C.
Rothenmaier, G. L.
Ruchie, W. H.
Schacht, E. W.
Schacht, R. J.
Schatz, W. R.
Schelble, F. J.
Schenkenberg, Grace E
Schleper, A. J.
Schneller, E. J.
Schroeder, H. T.
Schuster, Myron
Skow, G. D.
Smith, L. W.
Smullen, G. H.
Steffen, Elizabeth A.
Thackeray, R. C.
von Jarchow, B. L.
Walters, H. G
Williamson, W. H.
Woods, E. W.
Wright, R. S.

**Randolph:**
Horvath, D. C.

**Random Lake:**
Russell, J. A

**Reedsburg:**
Booher, J. A.
Hanko, J E
Knight, Robert G.
Pawlisch, O. V.
Rouse, J. J.
Stadel, E. V.

**Reedsville:**
Cary, E. C.

**Rhinelander:**
Bump, W. S.
Cline, Frances A.
Gager, W. F.
Harter, A F
Haug, Thomas M.
Komasinski, V W.
Magner, John P.
Osborne, R. R.
Richards, C. A.
Schiek, I. E.
Schiek, I. E., Jr.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

**Rice Lake:**
Eidsmoe, N. A.
Johnson, A. G.
Larson, Harry H.
MacMillan, D. G.
Maser, J. F.
Rydell, O. E.
Rydell, W. B.
Vaudreuil, W. F.

**Richfield:**
Kern, T. J.

**Richland Center:**
Edwards, W. C.
Glise, Roy C.
Hinke, D. H.
Housner, R. E.
Meyer, K. H.
Parke, George, Jr.
Pippin, B. I.
Pippin, L. M.
Sholtes, C. A.
Spear, Jack
Taft, D. J.

**Rio:**
Maas, W. C.

**Ripon:**
Bachus, A. C.
Cole, D. F.
Dittmer, O. A.
Johnson, J. M.
La Ham, J. T.
Mauthe, Howard
Schuler, W. H.
Watson, E. L.

**River Falls:**
Cairns, R. U.
Gutzler, P. H.
Haskins, P. S.

**Roberts:**
Ford, A. M.

**Rosholt:**
Benn, V. A.

**St. Croix Falls:**
Belshe, J. C.
Riegel, F. B.
Riegel, J. A.

**Sauk City:**
Bachhuber, H. A.
Kraus, B. F.
Walsh, T. W.

**Sawyer:**
Olsen, W. J.

**Seymour:**
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

**Sharon:**
Schrock, J. B.

**Shawano:**
Bauer, Frederick
Cantwell, A. A.
Cantwell, R. C.
Henke, F W
Jeffries, Donald A.
Klotz, Arthur P.
Marsh, H. C.
Peterson, L. W.
Rivard, R. R.
Schutz, W. J.

Sebesta, A. J.
Thimke, H. E.

**Sheboygan:**
Bassewitz, P. P.
Bock, A. B. C.
Bringe, J. W.
Differt, C. C.
Duckering, Florence A.
Eckardt, B. F.
Eigenberger, Friedrich
Giesen, C. P.
Gruenwald, Ludwig
Gunther, T. J.
Heiden, H. H.
Hidde, F. G.
Hildebrand, J. F.
Hoon, J. R.
Hougen, E. T.
Huibregtse, W. G.
Juckem. G. J.
Keane, K. M.
Knauf, A. J.
Kolb, F. K.
Kovacic, J. F.
Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Moir, Jane M.
Moir, W. W.
Nause, F. A.
Nause, F. P.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Russell, J. H.
Schmitt, A. J.
Schott, E. G.
Schroeder, I. L.
Simonson, L. M.
Simpson, R. M.
Squire, C. A.
Tasche, C. T.
Tasche, L. W.
Tompsett, A. C.
Van Driest, J. J.
Weber, C. J.
Winsauer, H. J.
Wood, H. R.
Wood, R. A.
Zaegel, R. L.
Ziel, H. A., Jr.

**Sheboygan Falls:**
Hansen, H. J.
Leighton, F. A.
Pfeiler, A. G.

**Shell Lake:**
Moen, D V.
Welter, D. J.

**Shiocton:**
LaCroix, G. M.

**Shullsburg:**
Garland, D. J.
Gratiot, Mary P.
Hoesley, H. F.

**Silver Lake:**
De Witt, C. A.

**Siren:**
Grindall, G. A.

**Slinger:**
Prefontaine, K. F.

**Soldiers Grove:**
Sannes, W. A.

**Solon Springs:**
Wilcox, A. G.

**South Milwaukee:**
Crigler, R. R.
Dempsey, G. P.
Flaherty, G. S.
Grimm, J. J.
Murphy, G. V.
Oberfeld, H. H.
O'Leary, W. J.
Rumph, C. L.

**Sparta:**
Beebe, D. C.
Beebe, S. D.
Brown, J. D.
Harris, A J.
Lukasek, E. O.
Mannis, Harry
Van Susteren, J. A.
Williams, H. H., Jr.

**Spencer:**
Callahan, H. T.

**Spooner:**
Olson, L. J.
Sahs, M. H.

**Spring Valley:**
Hill, E. F.

**Stanley:**
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.

**Statesan:**
Pummer, L. R.
White, E. F.

**Stevens Point:**
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Cowan, W. F.
Crosby, E. P.
Dunn, A. G.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
Iber, F. C.
Kidder, E. E.
Litzow, J. A.
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Sanders, R. H.
Sheehan, W. C.
Slater, R. H.
Sowka, P. N.
Wislol, Erich

**Stockbridge:**
Knauf, J. A.

**Stoughton:**
Nordholm, V. W.
Peterson, R. K.
Schoenbeck, R. F.
Smedal, A. T.

**Stratford:**
Kroepiin, F. C.

**Strum:**
Pfeiffer, L. R.

**Sturgeon Bay:**
Beck, J. G.
Dorchester, D. E.
Grota, H. D.
Huff, F. C.
Muehlhauser, J. O.
Peters, H. R.
Sheets, W. G.

**Sturtevant:**
Peehn, F. G.

**Sun Prairie:**
Behrend, J. F.
Grab, J. A.
Nelson, E. J.
Peterson, Leo W.
Russell, W. T.

**Superior:**
Anderson, R. T.
Beebe, L. W.
Carpenter, E. E.
Christianson, H. B.
Doyle, T. J.
Droege, C. T.
Easton, J. W.
Ekbiad, V. E.
Finn, Milton
Fruehauf, R. P.
Giesen, Charles W.
Giesen, Conrad W.
Heisel, J. G.
Johnson, F. G., Jr.
Kyllo, J. C.
Lavine, M. M.
McGill, J. W.
McGinnis, J. P.
Picard, C. J.
Reibold, F. W.
Rosin, L. R.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.
Weisberg, J. H.

**Suring:**
Dougherty, J. S.
Sandgren, G. R.

**Sussex:**
Van Valin, E. C.

**Theresa:**
Langenfeld, G. P.
Langenfeld, P. F.

**Thiensville:**
Elbe, T. D.
Scholz, H. F.

**Thorp:**
Jorgensen, Eleanora F.
Jorgensen, P. B.
Nels, F. P.

**Tigerton:**
Heise, L. F.
Rogers, R. M.

**Tomah:**
Konicek, R. G.
Kozarek, C. E.
Landmann, G. A.
Mubarak, J. S.
Scheurich, L. G.

**Tomahawk:**
Baker, G. R.
Baker, R G.
Jarvis, D. F.
Jarvis, E. C.
McCormick, W. C.

**Two Rivers:**
Kozelka, A. W.
Kuljis, D. A.
Marshall, W. S.
Martin, R. E.
Weld, S. L.
Zlatnik, A. P.

**Union Grove:**
Haedike, W. D.
McCracken, R. W.
Schulz, G. J.

**Verona:**
Weiland, H. P.

**Viola:**
Meboe, Joseph

**Viroqua:**
Ender, C. A.
Gulbrandsen, L. F.
Hirsch, R. S.
Oppert, H. E.
Vig, De Verne W.
Vig, E. N.

**Wabeno:**
Reddick, G. H.
Tenley, O. S.

**Walworth:**
Coon, W. W.
Kroyer, T. J.

**Washburn:**
Guzzo, Harold

**Waterford:**
Dietz, R. J.

**Waterloo:**
Allen, S. C.
Kennedy, F. H
Schmidt, C. W.

**Watertown:**
Brazos, J. C.
Burzynski, E. E.
Dierker, O. F.
Hadley, John O.
Hahn, A. C.
Haney, F. C.
Kosanke, F. E.
Miller, E. A.
Nowack, L. H.
Nowack, L. W.
Welbourne, R. P.
Zimmerman, F. H.

**Waukesha:**
Bartos, J. A.
Bolger, James V.
Bolger, James V., Jr.
Brown, W. E.
Campbell, P. E.
Campbell, W. B.
Clothier, W. J. K.
Davies, E. B.
Davies, Gwllym
Edmondson, C. C.
Eisele, Paul L.
Federman, E. H.
Frick, J. C.
Gantz, H. A.
Grosskopf, E. C.
Houston, H. S.
Merkow, William
Promer, J. E.
Scheele, F. M.
Seno, Elvira C.
Settlage, H A.
Smirl, W. G.
Sweed, Aaron
Sydow, H. F.
Thompson, F. A.
Werra, M. J
Williams, A. J.
Wood, C. A.
Zietlow, F. G.

**Waunakee:**
Allen, J. R.
Jackson, J. A.
Marquis, W. R.

**Waupaca:**
Boudry, M. O.
Haman, K. L.
Patterson, L. G.
Saian, Sam
Steiner, J. H.

**Waupun:**
Ferguson, E. C.
Hebenstreit, A. J.
Hull, H. H.
Petters, W. J.
Reslock, C. P.
Schrank, L. W.
Schrank, R. E.
Wagner, W. A.

**Wausau:**
Becker, W. T.
Brick, E. B.
Brodhead, R. H.
Burek, A. W.
Burr, Thurl C., Jr.
Christensen, H. W.
Davis, Helen Crawford
Fechtner, H. H.
Fehland, H. R.
Flannery, J. V.
Flemming, E. E.
Foerster, J. M.
Freeman, J. M.
Green, D. M.
Hammes, G. R.
Hendrickson, A. O.
Hendrickson, W. O.
Hoessel, A. W.
Jackson, J. A.
Jones, M. L.
Kelley, O. R.
Larsen, R. B.
Ludwig, E. P.
McCandless, E. E.
Miller, W. C.
Prenn, F. C.
Schroth, G. J.
Shannon, R C.
Smith, B. K.
Smith, S. M. B.
Stahmer, A. H.
Stahmer, K. H.
Stevens, G. H.
Wilson, O M.
Yoran, C. M.
Zagaria, J. F.

**Wautoma:**
Beck, A. A.
Darby, R. C.
Shemanski, L. S.
Slattery, F. G.
Wright, C. A.

**Wauwatosa:**
Banyai, A. L.
Beck, K. H.
Beffel, J. M.
Brand, W. D.
Brussock, W. A.
Burgardt, G. F.
Cadden, A. V.
Curtis, William C.
Danziger, Lewis
Dettmann, N. F.
Deysach, L. J.
Donath, L. H.
Engstrom, W. W.
Fifrick, L. L.
Glienke, C. F.
Harkness, John W.
Kasak, Michael
Kehlnhofer, F. H.
Kindwall, J. A.
Klopfer, W. P.
Kocovsky, C. J.
Kradwell, W. T.
Liefert, K. A.
Liefert, Wm. C.
McCormick, G. E.
Morrison, R. C.
Mueller, Joseph J.
O'Connell, James R.
Osgood, C. W
Pendergast, T. J.
Puchner, T. C.
Rettig, F. E.
Sargeant, H. W.
Schoene, F. C.
Seifert, K. A.
Seymer, L. A.
Stokdyk, G. A.
Truitt, J. W.
Winters, K. J.
Worm, G. J.

**Webster:**
Maas, D. A.

**West Allis:**
Brumbaugh, E. V.
Collins, E. G.
Couch, T. T.
Dohearty, W. H.
Everts, E. L.
Frederick, R. H.
Heinan, F. C.
Hermann, W. C.
Malensek, M. C.
Nefches, M. S.
Ohlsen, M. P.
Olmstead, E. G.
Smits, R. H.
Stamm, M. P.
Stern, C. S.
Stern, L. S.
Toepfer, R. A.
Wilkinson, E. D.
Wilkinson, J. J.

**West Bend:**
Bauer, K. T.
Baumgartner, J. F.
Bernhardt, E. L.
Bush, F. I.
Drlessel, R. H.
Driessel, S. J.
Frankow, R. O.
Grundahl, A. T.
Heldner, A. H.
Kauth, P. M.
Koehler, J. P.
Nielsen, W. A.
Pick, J. W.
Scheunemann, W. E.

**Westby:**
Bland, P. T.

**West DePere:**
Lenz, R. B.

**Westfield:**
Fredrick, H. Y.

**West Salem:**
Goedecke, R. H.
McNeilus, V. E.
Wakefield, G. F.

**Weyauwega:**
Weller, E. A.

**Whitehall:**
MacCornack, R. L.
Simons, N. S.
Simonson, S. W.

**Whitelaw:**
Gutheil, D. A.

**Whitewater:**
Ambrose, S. H.
Meighan, P. P.
Miller, R. H.

**Wild Rose:**
Hadden, Shirley L.
Hong, Roy
Van Ells, L. A.

**Williams Bay:**
Wiswell, C. Y.

**Winnebago:**
Braun, R. F.
Murphy, J. H.
Petersik, J. T.

**Wisconsin Dells:**
Broderick, C. F.
Ellenz, G. B.
Gissal, F. W.
Houghton, J. H.

**Wisconsin Rapids:**
Debus, E. E.
Garrison, R. E.
Glenn, E. C.
Handy, G. H.
Hulme, A. W.
Nelson, W. L.
Pomainville, F. X.
Pomainville, H. G.
Pomainville, L. C.
Shields, G. G.

**Withee:**
Johnson, J. W.

**Wittenberg:**
Olson, M. H.

**Wonewoc:**
Baker, H. P.

**Wood:**
Ciccantelli, Mark J.
Dessel, B. H.
Grueninger, A. J.
Jones, L. E.
Kuhl, Howard L.
Lehman, R. H.
Levin, J. J.
Lubitz, J. M.
Morrison, Thomas
Pfeffer, T. J.
Piaskoski, R. G.
Schwarz, R. J.
Shanberge, J. N.
Sosman, Abe
Spencer, G. N.
Webb, Wm. C.

**Woodruff:**
Newcomb, Kate P.
Pfeiffer, O. W.

**Woodville:**
Heiser, P. Arthur

**Wrightstown:**
Vande Loo, F. B.

**Wyocena:**
de Neveu, A. V.

# Members Serving in the Armed Forces

Albrecht, Donald J. --------Edwards AFB, California
Altman, J. S. ----------Great Lakes, Illinois
Arneth, John J. ----------Milwaukee, Wisconsin
Arvold, D. S. ----------Shawano, Wisconsin
Ashe, H. S. ----------Cherry Point, North Carolina
Bachhuber, Hugo M. ----------No known address
Balliet, C. M. ----------Wausau, Wisconsin
Becker, I. M. ----------Oakland, California
Becker, R. J. ----------Shorewood, Wisconsin
Benkendorf, Charles ----------Miami, Florida
Bennett, John C. ----------San Francisco, California
Beno, Thomas J. ----------Green Bay, Wisconsin
Brandt, Eugene F. ----------New York, New York
Brook, J. J., Jr. ----------Albuquerque, New Mexico
Brown, W. F. ----------Roslindale, Massachusetts
Buhl, Thomas L ----Travis Air Force Base, California
Bultema, James H. ----------Muskegon, Michigan
Burns, T. A. ----------No known address
Caskey, H. S. ----------New York, New York
Christofferson, James W. -------Great Lakes, Illinois
Cofrin, David A. ----------Enid, Oklahoma
Coheen, Jack J. ----------Fort Lewis, Washington
Cooney, Robert F. ----------San Francisco, California
Cornwall, Milton A. ----% P. M., New York, New York
Couch, James R. ----------Milwaukee, Wisconsin
Cowle, Arch E. ----------Great Lakes, Illinois
Dall, Glenn Alfred --------Fort Sam Houston, Texas
Danforth, Harold J. ----------Oshkosh, Wisconsin
Davee, Chalmer ----------Edgewater, Mississippi
Davis, Nathan S., Jr. ----------No known address
Davis, Thayer C. ----------Beaver Dam, Wisconsin
Duffy, Haydon R. ----------El Toro, California
Ferguson, Samuel H. ----------El Paso, Texas
Flynn, Robert A. --% P.M., San Francisco, California
Foley, Thomas J. ----------Milwaukee, Wisconsin
Foster, Thomas D.
----------Fleet P.M., San Francisco, California
Fox, Gerald E. ----------Forest City, Iowa
Frederick, John J. ----------San Antonio, Texas
Frisch, John G. ----------Milwaukee, Wisconsin
Froehlke, Theodore P. ----------No known address
Frye, John W. ----------Colorado Springs, Colorado
Gerth, R. E. ----------Oshkosh, Wisconsin
Grubb, Kenneth P., Jr. ----------Evanston, Illinois
Harris, Henry W. ----------Aurora, Colorado
Hartzell, Richard L. ----------Boise, Idaho
Haugh, John J.-----% P.M., San Francisco, California
Headlee, Charles R. ----------Wauwatosa, Wisconsin
Heinz, Harold N. ----------Sheboygan, Wisconsin
Hildebrand, James F. ---------Sheboygan, Wisconsin
Hobbins, William B. ------Colorado Springs, Colorado
Holmes, Chester L. ----% P.M., New York, New York
Hovda, A. A. ----------Tomah, Wisconsin
Huston, Erwin S. ----------Bremerton, Washington
Huston, John, Jr. ----------Milwaukee, Wisconsin
Jackson, Sidney C. ----------No known address
Jensen, Richard E. ----------No known address
Junkerman, Charles L. ----------No known address
Kabler, J. D. ----------Wichita, Kansas
Kagen, Louis ----------North Chicago, Illinois
Kanin, H. J. ----------San Antonio, Texas
Kelble, J. A. ----------Milwaukee, Wisconsin
Keller, Leigh W. ----------No known address
Kellogg, Lloyd S. ----------Oregon, Wisconsin
Kelly, C. M., Jr. ----------Sanoma, California
Kinsey, Jack La Vergne ----New London, Connecticut
Kohn, Albert M. ----------Milwaukee, Wisconsin
Kozokoff, Norman J.-% P.M., San Francisco, California
Kuehn, Alvin E. ----------Fort Sam Houston, Texas
Lawler, P. J. ----------Milwaukee, Wisconsin
Leiser, Alfred E. ----------Greenville, South Carolina
Le Tellier, Mason S.-% P.M., San Francisco, California
Liebenow, R R.-----% P.M., San Francisco, California
Lindemann, Charles E.---------Minneapolis, Minnesota
Lipscomb, Thomas C.
----------Aberdeen Proving Ground, Maryland
Little, William J. --------Phoenixville, Pennsylvania
Lohr, William H. ----------Lebanon, Oregon
Lohrman, George H.----% P.M., New York, New York
Longley, Bruce J. ----------Fort Knox, Kentucky
Macht, Arthur J.
----------Marshfield Clinic, Marshfield, Wisconsin
Matthiesen, Don E. -----Green Cove Springs, Florida
McCabe, Lloyd B. ----------Fond du Lac, Wisconsin
McCreary, William K. -------Temple City, California
McLaughlin, Brian C. ---------Milwaukee, Wisconsin
Means, James A.---% P.M., San Francisco, California
Mickle, Kenneth C. ----------Green Bay, Wisconsin

Miller, John P.—Wright-Paterson AFB, Dayton, Ohio
Moore, James N. ----------Youngstown, Ohio
Muscato, George V., Jr. ----Fort Campbell, Kentucky
Nelson, Marvin W. ----------Milwaukee, Wisconsin
Nelson, Pierce D. ----------Pensacola, Florida
Nichols, George P. -------Colorado Springs, Colorado
Nilles, J. E. --------% P.M., San Francisco, California
Noble, John H. ---------Black River Falls, Wisconsin
Ogilvie, O. Edward ----------Salt Lake City, Utah
Olson, Donald E. ----------Denver, Colorado
O'Malley, Richard J. ----------Milwaukee, Wisconsin
Otterhoit, Erland R. ----------Janesville, Wisconsin
Phillips, Paul W. ----------Portsmouth, Virginia
Pierson, Paul S. ----------Great Lakes, Illinois
Podruch, Philip E.—% P.M., San Francisco, California
Powell, Richard A. ----------Pensacola, Florida
Pranke, D. W. ----------Beloit, Wisconsin
Pulito, Frank J. ----------Milwaukee, Wisconsin
Randolph, William C. ----------No known address
Redlin, Russell R. ----------Coronado, California
Rotter, Royal ----------Madison, Wisconsin
Rowlands, Owen B.
---Wright-Paterson Air Force Base, Dayton, Ohio
Royce, Marvin E. ----------Mayville, Wisconsin
Salter, Robert K. ----------El Paso, Texas
Samuelson, Clarence----Scott Air Force Base, Illinois
Sattler, M. E. ----------Amarillo, Texas
Savino, Pasquale R. ----------Denver, Colorado
Savory, Paul B. ----------No known address
Schaefer, Harry E. ----------Manitowoc, Wisconsin
Schalmo, Edwin H., Jr.—Camp Breckenridge, Kentucky
Schelbe, James A. ----------New York, New York
Scheller, Robert F. ----Fort Leonard Wood, Missouri
Schlenker, Leo T. ----------Fort Ord, California
Schmidt, C. H. -----Castle Air Force Base, California
Schmitt, G. D.—Mountain Home Air Force Base, Idaho
Schoen, Roland F. ----------New York, New York
Schreiber, Manuel K. --------Los Angeles, California
Schroeder, R. W. ----------Fond du Lac, Wisconsin
Semmens, James P. ---------Port Chicago, California
Simon, George M. ----------Manitowoc, Wisconsin
Sinnett, James Monroe
----------Fleet Post Office, New York, New York
Slomowitz, Jonathan ----------Great Lakes, Illinois
Starr, Robert A. ----------No known address
Stokke, O. H. ----------Milwaukee, Wisconsin
Stollenwerk, Kenneth J. ---Fort Campbell, Kentucky
Sweeney, Thomas C. ---------Williamville, New York
Taniguchi, Tukuso ----------No known address
Thiede, Walter E. ----------Great Lakes, Illinois
Thomas, Walton D. ----------Milwaukee, Wisconsin
Tverberg, Miltzo S. ----------Camp Crowder, Missouri
Urbanek, Robert E. ---------Beaver Dam, Wisconsin
Walker, John P. ----------Mondovi, Wisconsin
Waters, Darwin D. ----------Madison, Wisconsin
Watzke, Donald F. ------% P.M., Seattle, Washington
Weber, Marshall L. ------% P.M., Seattle, Washington
White, Douglas H. ----------Indianapolis, Indiana
Wolf, L. P. --------% P.M., San Francisco, California
Worobec, R. N. ----------Fort Belvoir, Virginia

# Out-of-State Members

Anderson, N. P. ----------Crystal River, Florida
Anderson, W. A. D. ----------Coral Gables, Florida

Barnes, Milford E., Jr.----Wilkes-Barre, Pennsylvania
Barnes, J. S. ----------Albuquerque, New Mexico
Baum, E. L. ----------Naples, Florida
Beutler, Theodore V. ----------Fort Wayne, Indiana
Bleyer, L. F. ----------Providence, Rhode Island
Boren, James A. ----------Rochester, Minnesota
Bruns, D. H. ----------Camarillo, California

Cameron, Eugenia S. ---------Northford, Connecticut
Cameron, Norman ----------New Haven, Connecticut
Capparell, Homer V. -------Pittsburgh, Pennsylvania
Carroll, Gordon E. ----------Mobile, Alabama
Clahassey, Erwin G. --------Grand Rapids, Michigan
Coffin, L. E. ----------Tucson, Arizona
Cranston, Robert W., III -------Tioga, North Dakota
Creasy, Leurner E. ----------No known address

Davis, Helen P. ----------Phoenix, Arizona
Dixon, Ward George ----------Dallas, Texas

Eisen, H. L. ----------Ontario, California
Epperson, Keith D. ----------No known address

Fabric, Ben Lue ----------Miami Beach, Florida
Fogo, Alden E. ----------No known address
Frank, Herbert ----------Fargo, North Dakota
Froeschle, Rudolph P. ----------Tioga, North Dakota

Gillies, William G. ----------Galena, Illinois
Grant, L. C., Jr. ----------New York, New York
Gross, T. A. ----------Nashville, Tennessee
Guckien, Joseph L. ----------Camden, Indiana
Gulbrandsen, Halbert ----------Denver, Colorado

Haentzschel, Lester E. ------Taunton, Massachusetts
Haley, H. B. ----------Boston, Massachusetts
Handa, Yoshio ----------Hines, Illinois
Horwich, Harry ----------Long Island, New York
Hotter, John T. ----------Iowa City, Iowa
Hugo, George J. ----------Campbell, California
Huth, Edgar W. ----------Anna Maria, Florida

Ives, Donald G. ----------Ann Arbor, Michigan

Jackson, R. C. ----------Rochester, Minnesota
Johnson, H. C. ----------Eugene, Oregon
Johnson, R. D. ----------Ann Arbor, Michigan
Jones, F. S. ----------Big Stone Gap, Virginia

Keating, Joseph L. ----------Temple, Texas
Kersting, David W. ----------Chicago, Illinois
Kilkenny, T. E. ----------New Orleans, Louisiana
Klepfer, Jefferson F. ----------Richmond, Indiana
Koepsell, James E. ----------Rockford, Illinois
Kukral, Albert J. ----------Denver, Colorado

Lamal, A. H. ----------Watford City, North Dakota
Larkey, J. A. ----------Philadelphia, Pennsylvania
Lindberg, Charles O. ----------Sandstone, Minnesota

Malloy, David J. ----------Maywood, Illinois
Mann, George A. ----------St. Paul, Minnesota
Mathewson, Russell C. ---------Whitfield, Mississippi
Mazzitello, W. F. ----------St. Paul, Minnesota
McLeod, John J., Jr. ----------Rochester, Minnesota
Megna, Salvatore ----------Tucson, Arizona
Merdinger, Walter F., Jr. -----Boston, Massachusetts
Miale, John B. ----------Miami, Florida

Nicolai, Charles H. ----------St. Louis, Missouri
Niver, Edwin O. ----------Cleveland Heights, Ohio

Oakley, Dorothy H. ----------Clinton, Massachusetts
O'Donnell, Mae J. ----------Wadsworth, Kansas

Pedersen, Elaine K. ------Philadelphia, Pennsylvania
Pinney, James C. ----------Washington, D. C.
Plank, Le Roy E. ----------Albuquerque, New Mexico

Riegel, Gordon S. --------Colorado Springs, Colorado

Sanders, Donald D. ----------No known address
Searle, D. R. ----------Safety Harbor, Florida
Sivertson, Sigurd E. ----------Rochester, Minnesota
Strand, Clarence M. ----------Chicago, Illinois
Sweeney, James D. ----------Spokane, Washington

Talbert, Myron J. --------Grand Forks, North Dakota
Taylor, J. Gurney ----------Miami, Florida
Teresi, J. L. ----------Saratoga, California
Trumbo, James K. ----------Augusta, Georgia
Tuchscherer, Mabel E. ----------Butte, Montana

Usow, John M. ----------Beverly Hills, California

Vander Kamp, Harry ----------Kalamazoo, Michigan
Van Kirk, F. W. ----------Beverly Hills, California
Van Riper, H. E. ----------New York, New York

Wallner, Alfred ----------Kalispell, Montana
Waters, R. M. ----------Orlando, Florida
Wells, May R. ----------Belleville, Illinois
Wilson, N. M. ----------Elmhurst, Illinois

# Life Members of State Medical Society

Allen, W. J. ---------- Beloit

Barnes, J. S. ---------- Milwaukee
Beebe, L. W. ---------- Superior
Beebe, S. D. ---------- Sparta
Belitz, A. E. ---------- Pepin
Bolton, E. L. ---------- Appleton
Boyce, S. R. ---------- Gays Mills
Brehm, H. J. ---------- Racine
Brooks, E. H. ---------- Bloomington
Brunckhorst, F. O. ---------- Neenah

Cairns, R. U. ---------- River Falls
Campbell, W. B. ---------- Waukesha
Caswell, H. O. ---------- Jefferson
Connell, F. G. ---------- Oshkosh
Crockett, W. W. ---------- Beloit
Crosby, E. P. ---------- Stevens Point
Cunningham, Wilson ---------- Platteville
Donohue, M. J. ---------- Antigo

Fazen, L. E. ---------- Racine
Folsom, W. H. ---------- Fond du Lac
Forkin, G. E. ---------- Menasha
Friend, L. J. ---------- Beloit

Gavin, S. E. ---------- Fond du Lac
Grosskopf, E. C. ---------- Waukesha
Hammond, F. W. ---------- Manitowoc
Hardgrove, J. H. ---------- Shawano
Haubrick, H. J. ---------- Oshkosh
Haushalter, H. P. ---------- Milwaukee
Heraty, J. E. ---------- La Crosse
Hipke, G. A. ---------- Milwaukee

Jackson, J. A. ---------- Wausau
Junck, J. A. ---------- Milwaukee

Kleinboehl, J. W. ---------- Mercer

Leonard, C. W. ---------- Fond du Lac
Linn, W. N. ---------- Oshkosh
Lockhart, C. W. ---------- Mellen
Lockhart, J. W. ---------- Oshkosh
Ludden, H. D. ---------- Mineral Point
Lumsden, William ---------- Menomonie
Lundmark, L. M. ---------- Ladysmith

Marshall, V. F. ---------- Appleton
Meusel, H. H. ---------- Oshkosh

Nadeau, A. T. ---------- Marinette
Notbohm, W. R. ---------- Dousman

Peehn, F. G. ---------- Sturtevant
Pomainville, F. X. ---------- Wisconsin Rapids
Pope, F. W. ---------- Racine

Quick, E. W. ---------- Milwaukee

Radloff, A. C. ---------- Plymouth
Raymond, R. G. ---------- Brownsville

Schein, J. E. ---------- Oshkosh
Schmidt, E. S. ---------- Green Bay
Schroeder, H. F. ---------- Marinette
Smith, S. M. B. ---------- Wausau

Tasche, C. T. ---------- Sheboygan
Thomas, W. O. ---------- Clinton
Twohig, D. J. ---------- Fond du Lac

Webb, E. P. ---------- Beaver Dam
Wheeler, W. P. ---------- Oshkosh
Witcpalek, W. W. ---------- Kewaunee

# Honorary Members of County and State Societies

Bradley, H. C. ---------- Madison
Clark, P. F. ---------- Madison
McCracken, R. W. ---------- Union Grove
Meek, W. J. ---------- Madison

Pusey, W. A. ---------- Chicago, Illinois
Sisk, I. R. ---------- Madison
Sullivan, W. E. ---------- Madison
Taylor, J. Gurney ---------- Miami, Fla.

## WISCONSIN ANTI-TUBERCULOSIS ASSOCIATION OFFERS TWO SCHOLARSHIPS

The Wisconsin Anti-Tuberculosis Association is offering two scholarships to qualified Wisconsin physicians to attend a four-week course in tuberculosis and certain phases of other chronic chest diseases, including those of occupational origin. This course will be conducted by the Trudeau School of Tuberculosis at Saranac Lake, New York, May 31, 1954, to June 25, 1954.

Scholarships are open to recent graduates of approved medical schools, with preference given to those men who have had some tuberculosis experience or who plan to specialize in internal medicine. Scholarships include the tuition fee of $100, transportation to Saranac Lake, New York, and return, and full maintenance—a total of $500. However, $250 is to be returned to the Wisconsin Anti-Tuberculosis Association within a period of five years.

The school has been approved for training of veterans under public laws 610 and 550, and those desiring to take advantage of the G.I. Bill of Rights rather than the scholarship referred to above should clear their registration with the Veterans Administration before the session opens.

Application for the WATA scholarships must be in the hands of the Committee by March 1, 1954.

For an application blank, write to Dr. A. A. Pleyte, Wisconsin Anti-Tuberculosis Association, 1018 North Jefferson Street, Milwaukee 2, Wisconsin.

# Constitution and By-Laws of the State Medical Society of Wisconsin*

## CONSTITUTION

### ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

### ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

### ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

### ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

* As amended by the 1953 House of Delegates.

### ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

### ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

### ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

### ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

### ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a member-

ship of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

## ARTICLE X

### FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a by-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

## ARTICLE XI

### REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

## ARTICLE XII

### SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

## ARTICLE XIII

### AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

# BY-LAWS

## CHAPTER I

### MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society, shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

## CHAPTER II

### GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

## CHAPTER III

### HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society, life members, affiliate members. associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of a date thirty days in advance of the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

## CHAPTER IV

### ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

## CHAPTER V

### DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the

regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The Secretary shall maintain certified copies of each component county society's constitution and by-laws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

## CHAPTER VI

### COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting during February for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

## CHAPTER VII

### COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Council on Scientific Work.
- A Council on Medical Service.
- A Committee on Public Policy.
- A Committee on Grievances.
- A Committee on Medical Education and Hospitals.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Hospital Relations.
- A Committee on Cancer.

Unless otherwise provided in these By-Laws, each of these committees shall consist of five members, each of whom shall serve for a term of five years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, four, and five years, and thereafter for terms of five years each.

SEC. 2. The Council on Scientific Work shall consist of five members, and each member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope

of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Council on Medical Service shall consist of nine members appointed by the president of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Council on Medical Service shall act to correlate activities of the Society in medical economic fields, and to inform the profession and the public of proposed changes affecting medical care in the state and the nation. It shall likewise study and suggest means for the improvement of the distribution of medical service to the public, and shall periodically inform county medical societies regarding its activities.

The Council shall direct the program of the Society in the field of public health education, and in such manner as is found suitable, shall seek to further the health of those employed in Wisconsin industry, as well as to promote the health and safety of those engaged in rural Wisconsin.

SEC. 4. The Committee on Public Policy shall consist of five members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years.

SEC. 6. The Committee on Medical Education and Hospitals shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

The deans of the two Medical Schools in Wisconsin shall be members of this Committee, in addition to those appointed annually.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

The Committee on Hospital Relations of the State Medical Society of Wisconsin is specifically charged with the responsibility of receiving and considering all complaints and/or queries from any physician, hospital, medical organization, or other interested person or group, relating to professional and/or economic problems occurring in the practice of medicine in hospitals wherein a dispute has arisen between a physician and a hospital. If the matter under consideration cannot be arbitrated by the good offices of the Committee on Hospital Relations, its findings to that effect shall be transmitted to the Council of the State Medical Society of Wisconsin with its findings and recommendations in order that the Council may then make suitable recommendations to the Judicial Council of the American Medical Association.

SEC. 9. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 10. The Wisconsin Medical Journal shall be the official Journal of the Society.

## CHAPTER VIII

### DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society

on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships:* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 7. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

## CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

## CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

## CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked or suspended shall be dropped from membership automatically as of the date of revocation or suspension. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of three years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to

appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. At some meeting in advance of the annual session of this Society, each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and by-laws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

## CHAPTER XII

### SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and expenditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

## CHAPTER XIII

### SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

## BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1954 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referral be made by the family physician; but when this is not feasible, arrangements may be made by writing to the Bureau. Forms for the purpose of referral may be obtained from the Bureau of Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify for which clinic forms are wanted.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of the fact.

| | |
|---|---|
| Ashland | February 10, 11 |
| Manitowoc | February 17, 18 |
| Marinette | February 24 |
| Kenosha | March 3, 4 |
| Racine | March 10, 11 |
| Green Bay | March 18, 19 |
| Eau Claire | March 25, 26 |
| Wausau | March 31, April 1 |
| La Crosse | April 6, 7, 8, 9 |
| Sheboygan | April 13, 14 |
| Superior | April 28, 29 |
| Appleton | May 6, 7 |
| Fond du Lac | May 12, 13 |
| Chippewa Falls | May 20, 21 |
| Rhinelander | June 2, 3 |
| Lancaster | June 10 |
| Darlington | June 11 |

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

# Principles of Medical Ethics of the American Medical Association

"These principles are not laws to govern but are principles to guide to correct conduct." (James Percival's Principles of Ethics 1803).

## CHAPTER 1

## GENERAL PRINCIPLES

### CHARACTER OF THE PHYSICIAN

SECTION 1.—The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Whoever chooses this profession assumes the obligation to conduct himself in accord with its ideals. A physician should be "an upright man, instructed in the art of healing." He must keep himself pure in character and be diligent and conscientious in caring for the sick. As was said by Hippocrates, "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life."

### THE PHYSICIAN'S RESPONSIBILITY

SEC. 2.—"The profession of medicine, having for its end the common good of mankind, knows nothing of national enmities, of political strife, of sectarian dissensions. Disease and pain the sole conditions of its ministry, it is disquieted by no misgivings concerning the justice and honesty of its client's cause; but dispenses its peculiar benefits, without stint or scruple, to men of every country, and party and rank, and religion, and to men of no religion at all."*

### GROUPS AND CLINICS

SEC. 3.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual physicians, each of whom, whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

### ADVERTISING

SEC. 4.—Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

### EDUCATION INFORMATION NOT ADVERTISING

SEC. 5.—Many people, literate and well educated, do not possess a special knowledge of medicine. Medical books and journals are not easily accessible or readily understandable.

The medical profession considers it ethical for a physician to meet the request of a component or constituent medical society to write, act or speak for general readers or audiences. The adaptability of medical material for presentation to the public may be perceived first by publishers, motion picture producers or radio officials. These may offer to the physician opportunity to release to the public some article, exhibit or drawing. Refusal to release the material may be considered a refusal to perform a public service, yet compliance may bring the charge of self seeking or solicitation. In such circumstances the physician should be guided by the decision of official agencies established through component and constituent medical organizations.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society.

The most worthy and effective advertisement possible, even for a young physician, especially among his brother physicians, is the establishment of a well merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

The promise of radical cures or boasting of cures or of extraordinary skill or success is unethical.

An institution may use means, approved by the medical profession in its own locality, to inform the public of its address and the special class, if any, of patients accommodated.

### PATENTS, COMMISSIONS, REBATES AND SECRET REMEDIES

SEC. 6.—An ethical physician will not receive remuneration from patents on or the sale of surgical instruments, appliances and medicines, nor

* Sir Thomas Watson.

profit from a copyright on methods or procedures. The receipt of remuneration from patents or copyrights tempts the owners thereof to retard or inhibit research or to restrict the benefits derivable therefrom to patients, the public or the medical profession. The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient. He should receive his remuneration for professional services rendered only in the amount of his fee specifically announced to his patient at the time the service is rendered or in the form of a subsequent statement, and he should not accept additional compensation secretly or openly, directly or indirectly, from any other source.

The prescription or dispensing by a physician of secret medicines or other secret remedial agents, of which he does not know the composition, or the manufacture or promotion of their use is unethical.

EVASION OF LEGAL RESTRICTIONS

SEC. 7.—An ethical physician will observe the laws regulating the practice of medicine and will not assist others to evade such laws.

## CHAPTER II

## DUTIES OF PHYSICIANS TO THEIR PATIENTS

STANDARDS, USEFULNESS, NONSECTARIANISM

SEC. 1.—In order that a physician may best serve his patients, he is expected to exalt the standards of his profession and to extend its sphere of usefulness. To the same end, he should not base his practice on an exclusive dogma or a sectarian system, for "sects are implacable despots; to accept their thralldom is to take away all liberty from one's action and thought."* A sectarian or cultist as applied to medicine is one who alleges to follow or in his practice follows a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and scientific experience. All voluntarily associated activities with cultists are unethical. A consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree in which it elevates the honor and dignity of those who are irregular in training and practice.

PATIENCE, DELICACY AND SECRECY

SEC. 2.—Patience and delicacy should characterize the physician. Confidences concerning individual or domestic life entrusted by patients to a physician and defects in the disposition or character of patients observed during medical attendance should never be revealed unless their revelation is required by the laws of the state. Sometimes, however, a physician must determine whether his duty to society requires him to employ knowledge, obtained through confidences entrusted to him as a physician, to protect a healthy person against a communicable disease to which he is about to be exposed. In such instance, the physician should act as he would desire another to act toward one of his own family in like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 3.—The physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives or his responsible friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

THE PATIENT MUST NOT BE NEGLECTED

SEC. 4.—A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice to the patient, his relatives or his responsible friends sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

## CHAPTER III

## DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

### ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLDING THE HONOR OF THE PROFESSION

SEC. 1.—A physician is expected to uphold the dignity and honor of his vocation.

MEMBERSHIP IN MEDICAL SOCIETIES

SEC. 2.—For the advancement of his profession, a physician should affiliate with medical societies and contribute of his time, energy and means so that these societies may represent the ideals of the profession.

SAFEGUARDING THE PROFESSION

SEC. 3.—Every physician should aid in safeguarding the profession against admission to it of those who are deficient in moral character or education.

SEC. 4.—A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession. Questions of such conduct should be consid-

* Nicon, father of Galen.

ered, first, before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations, provided such a course is possible and provided, also, that the law is not hampered thereby. If doubt should arise as to the legality of the physician's conduct, the situation under investigation may be placed before officers of the law, and the physician-investigators may take the necessary steps to enlist the interest of the proper authority.

### Article II.—Professional Services of Physicians to Each Other

#### DEPENDENCE OF PHYSICIANS ON EACH OTHER

Sec. 1.—As a general rule, a physician should not attempt to treat members of his family or himself. Consequently, a physician should cheerfully and without recompense give his professional services to physicians or their dependents if they are in his vicinity.

#### COMPENSATION FOR EXPENSES

Sec. 2.—When a physician from a distance is called to advise another physician about his own illness or about that of one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered him. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss may, in part at least, be provided for in the compensation offered.

#### ONE PHYSICIAN IN CHARGE

Sec. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select one physician to take charge of the case. The family may ask the physician in charge to call in other physicians to act as consultants.

### Article III.—Duties of Physicians in Consultations

#### CONSULTATIONS SHOULD BE ENCOURAGED

Sec. 1.—In a case of serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

#### CONSULTATION FOR PATIENT'S BENEFIT

Sec. 2.—In every consultation, the benefit to the patient is of first importance. All physicians interested in the case should be candid with the patient, a member of his family or a responsible friend.

#### PUNCTUALITY

Sec. 3.—All physicians concerned in consultations should be punctual. When, however, one or more of the consultants are unavoidably delayed, the one who arrives first should wait for the others for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any other reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or it be the desire of the patient, his family or his responsible friends, the consultant may examine the patient and mail his written opinion, or see that it is delivered under seal to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

#### PATIENT REFERRED TO CONSULTANT

Sec. 4.—When a patient is sent to a consultant and the physician in charge of the case cannot accompany the patient, the physician in charge should provide the consultant with a history of the case, together with the physician's opinion and outline of the treatment, or so much of this as may be of service to the consultant. As soon as possible after the consultant has seen the patient he should address the physician in charge and advise him of the results of the consultant's investigation. The opinions of both the physician in charge and the consultant are confidential and must be so regarded by each.

#### DISCUSSIONS IN CONSULTATIONS

Sec. 5.—After the physicians called in consultation have completed their investigations, they and the physician in charge should meet by themselves to discuss the course to be followed. Statements should not be made nor should discussion take place in the presence of the patient, his family or his friends, unless all physicians concerned are present or unless all of them have consented to another arrangement.

#### RESPONSIBILITY OF ATTENDING PHYSICIAN

Sec. 6.—The physician in charge of the case is responsible for treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, after such a change, it is best to call another consultation; then the physician in charge should state his reasons for departing from the course decided at the previous conference. When an emergency occurs during the absence of the physician in charge, a consultant may assume authority until the arrival of the physician in charge, but his authority should not extend further without the consent of the physician in charge.

#### CONFLICT OF OPINION

Sec. 7.—Should the physician in charge and a consultant be unable to agree in their view of a case, another consultant should be called or the

differing consultant should withdraw. However, since the patient employed the consultant to obtain his opinion, he should be permitted to state it to the patient, his relative or his responsible friend, in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has acted as consultant in an illness, he should not become the physician in charge in the course of that illness, except with the consent of the physician who was in charge at the time of the consultation.

## ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SEC. 1.—A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENTS OF ANOTHER PHYSICIAN

SEC. 2.—When a physician makes social calls on another physician's patient he should avoid conversation about the patient's illness.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in charge of a case, he should not disparage, by comment or insinuation, the one who preceded him. Such comment or insinuation tends to lower the confidence of the patient in the medical profession and so reacts against the patient, the profession and the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency because the personal or family physician is not at hand, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the personal or family physician. However, he should first report to the personal or family physician the condition found and the treatment administered.

PRECEDENCE WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident, the first to arrive should be considered the physician in charge. However, as soon as is practicable, or on the arrival of the acknowledged personal or family physician, the first physician should withdraw. Should the patient, his family or his responsible friend wish some one other than he who has been in charge of the case, the patient or his representative should advise the personal or family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital without the knowledge of the physician who is known to be the personal or family physician, the patient should be returned to the care of the personal or family physician as soon as is feasible.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during the colleague's temporary absence, or when, because of an emergency, a physician is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy that he would wish used in similar circumstances if the patient were his responsibility. The patient should be returned to the care of the attending physician as soon as possible.

SUBSTITUTION IN OBSTETRIC WORK

SEC. 8.—When a physician attends a woman who is in labor because the one who was engaged to attend her is absent, the physician summoned in the emergency should relinquish the patient to the first engaged, on his arrival. The one in attendance is entitled to compensation for the professional services he may have rendered.

## ARTICLE V.—DISPUTES BETWEEN PHYSICIANS

ARBITRATION

SEC. 1.—Whenever there arises between physicians a grave difference of opinion, or of interest, which cannot be promptly adjusted, the dispute should be referred for arbitration, preferably to an official body of a component society.

## ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SEC. 1.—Poverty of a patient, and the obligation of physicians to attend one another and the dependent members of the families of one another, should command the gratuitous services of a physician. Institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, should meet such costs as are covered by the contract under which the service is rendered.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—A physician should not dispose of his services under conditions that make it impossible to render adequate service to his patients, except under circumstances in which the patients concerned might be deprived of immediately necessary care.

CONTRACT PRACTICE

SEC. 3.—Contract practice as applied to medicine means the practice of medicine under an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization, political subdivision or individual, whereby partial or full medical services are provided for a group or class of individuals on the basis of a fee schedule, or for a salary or for a fixed rate per capita.

Contract practice *per se* is not unethical. Contract practice is unethical if it permits of features or conditions that are declared unethical in these Principles of Medical Ethics or if the contract or any of its provisions causes deterioration of the quality of the medical services rendered.

FREE CHOICE OF PHYSICIAN

SEC. 4.—Free choice of physician is defined as that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patients and physicians. The interjection of a third party who has a valid interest, or who intervenes between the physician and the patient does not *per se* cause a contract to be unethical. A third party has a valid interest when, by law or violation, the third party assumes legal responsibility and provides for the cost of medical care and indemnity for occupational disability.

COMMISSIONS

SEC. 5.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, the giving or receiving of a commission by whatever term it may be called or under any guise or pretext whatsoever is unethical.

PURVEYAL OF MEDICAL SERVICE

SEC. 6.—A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people.

## CHAPTER IV

## THE DUTIES OF PHYSICIANS TO THE PUBLIC

PHYSICIANS AS CITIZENS

SEC. 1.—Physicians, as good citizens, possessed of special training, should advise concerning the health of the community wherein they dwell. They should bear their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic prevails, a physician must continue his labors without regard to the risk to his own health.

PHARMACISTS

SEC. 3.—Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine.

## CONCLUSION

These principles of medical ethics have been and are set down primarily for the good of the public and should be observed in such a manner as shall merit and receive the endorsement of the community. The life of the physician, if he is capable, honest, decent, courteous, vigilant and a follower of the Golden Rule, will be in itself the best exemplification of ethical principles.

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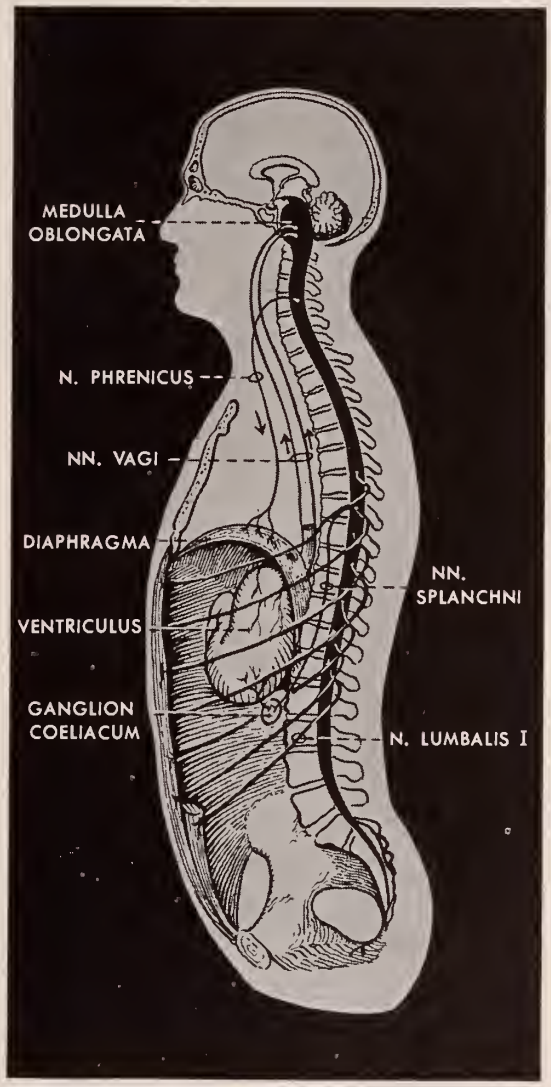
1. Keats, S.: Ataxic Cerebral Palsy with Akinetic Seizures: Dramatic Response to Dramamine, J. M. Soc. New Jersey *50*:53 (Feb.) 1953.
2. Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1953, Philadelphia, J. B. Lippincott Company, 1953, p. 471.




THE VOMITING REFLEX: *Vagus→ nodose ganglion→ solitary tract→ spinal cord→ cervical, thoracic and lumbar nerves to diaphragm, cardiac sphincter, stomach, abdominal and pelvic musculature. (After Krieg, W. J. S.: Functional Neuroanatomy, ed. 2, New York, The Blakiston Company, Inc., 1953, p. 104.)*

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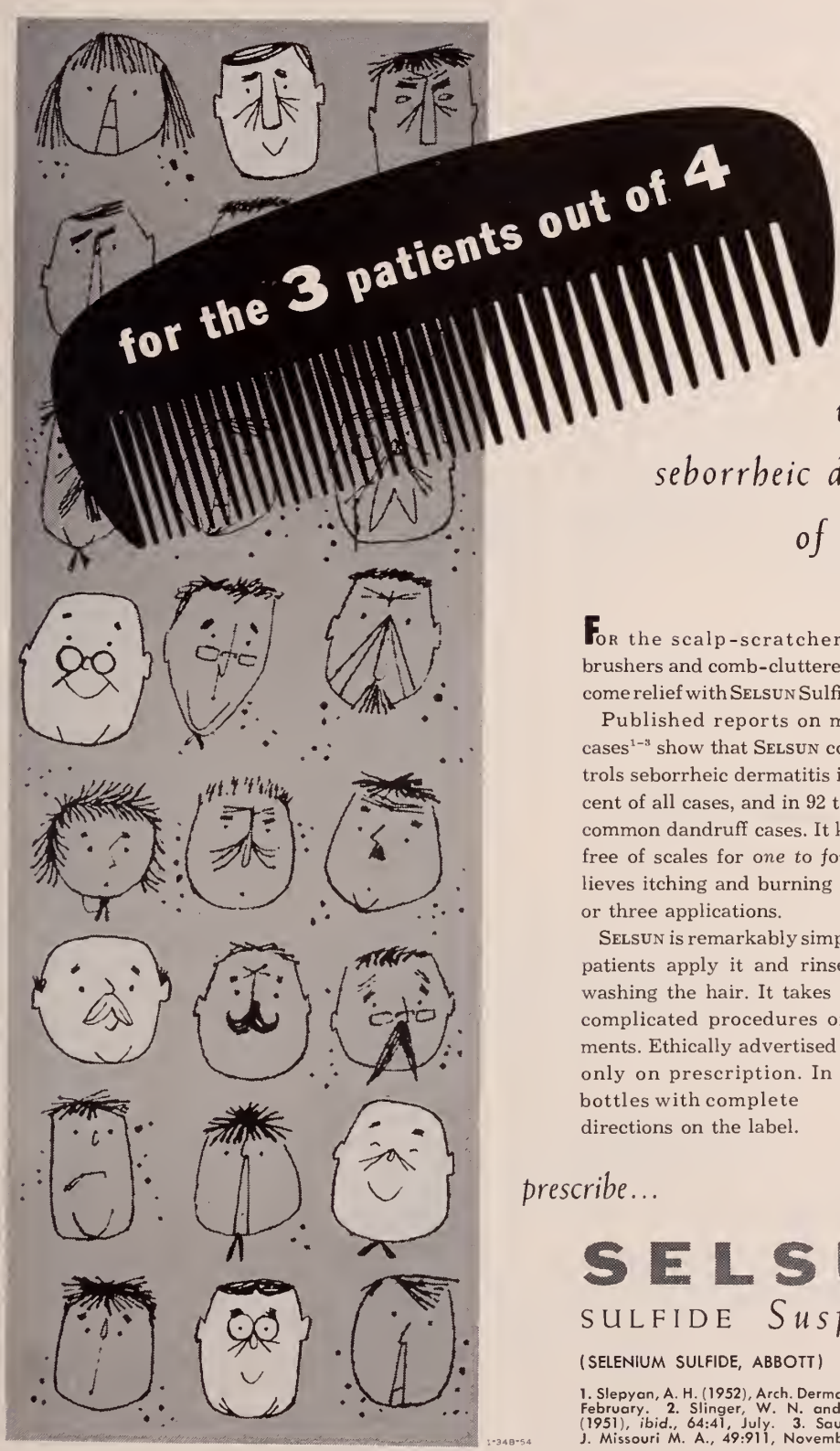


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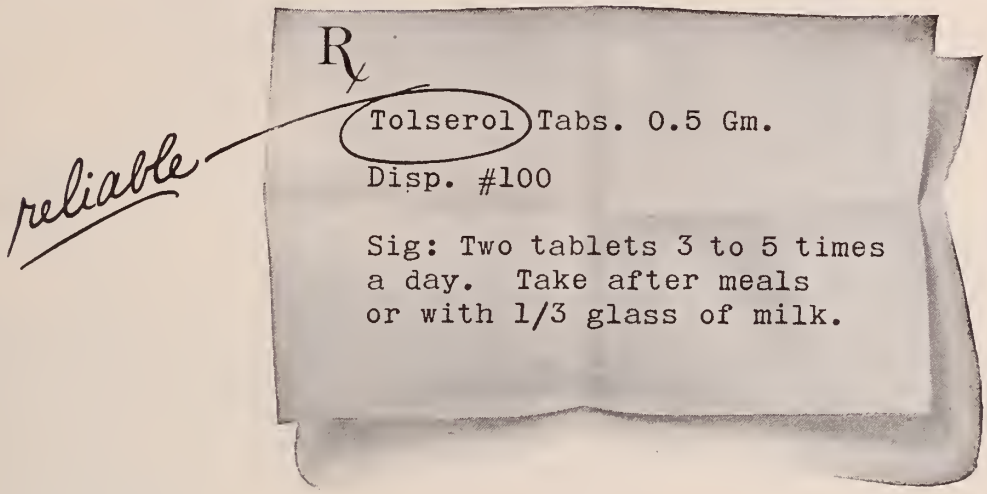


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## 1953–54 SCHOLARSHIPS AVAILABLE IN PLASTIC AND RECONSTRUCTIVE SURGERY

The Foundation of the American Society of Plastic and Reconstructive Surgery announces the regulations of the Fifth Annual Scholarship Contest:

1. The contest in Junior Classification is restricted to residents in training and to plastic surgeons who have been in practice no longer than five years.
2. Two main prizes are offered, each consisting of a three-months' plastic surgery scholarship with full maintenance in a number of selected leading services, in the United States and abroad.
3. The subject matter of the essay must be the result of some original research (either clinical or experimental) in the field of plastic and reconstructive surgery. The thesis should be of about 5,000 words, and written in English.
4. Work previously published wholly or in part is not acceptable.
5. Expenses of travel between the services will be allotted.
6. A silver plaque or a certificate of honorable mention is also offered for a winning essay in Senior Classification to contestants active in practice of plastic and reconstructive surgery for more than five years.
7. Manuscripts will not be accepted by the Award Committee after July 1, 1954.
8. The winning essays will be presented in person at a formal program of the Foundation of the American Society of Plastic and Reconstruction Surgery to be held in the fall of 1954.

For further information, write to the Award Committee, % Jacques W. Maliniac, M.D., Chairman, 30 Central Park South, New York, N. Y.

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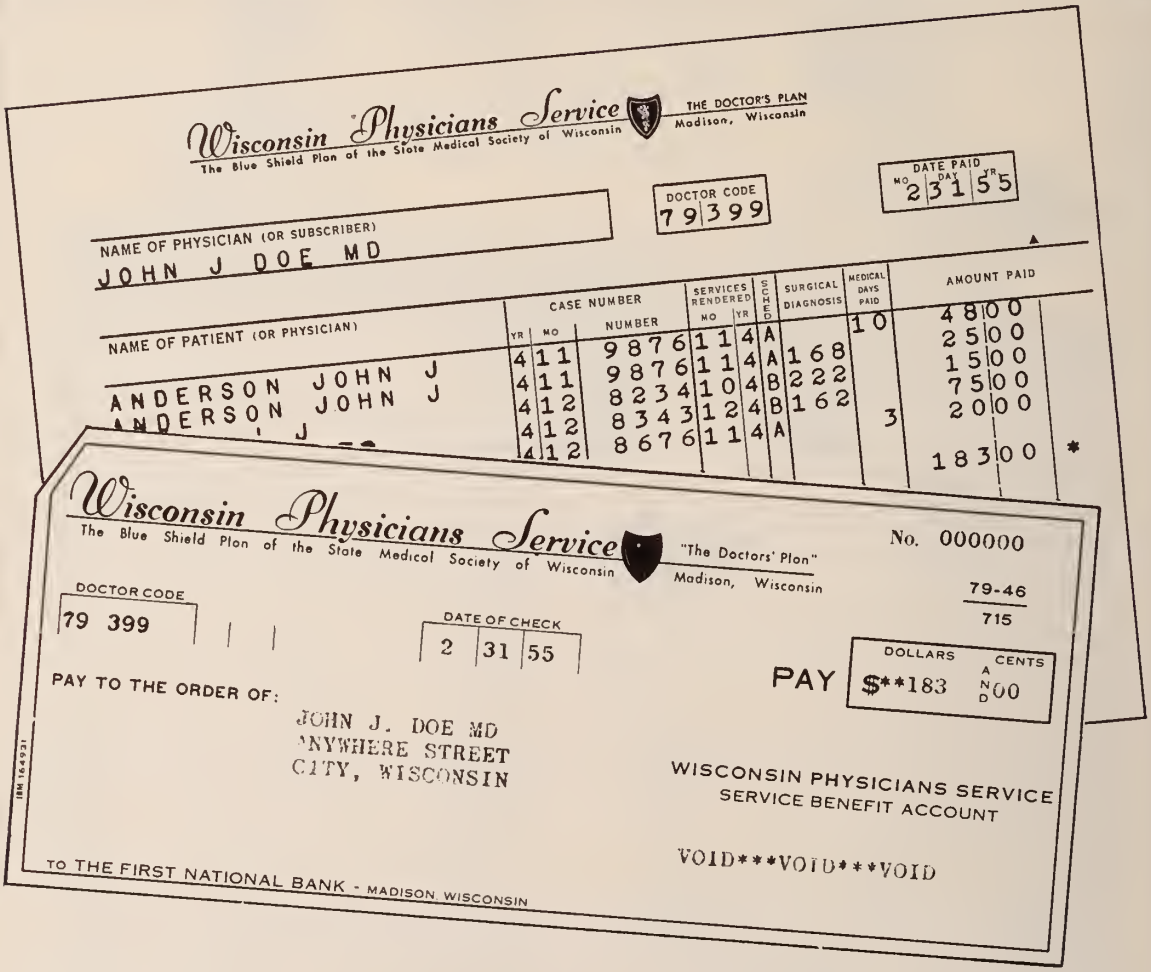

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Mason C. Darling, Fond du Lac 1841–1847
J. B. Dousman, Milwaukee 1848, 1849
A. L. Castleman, Delafield 1850, 1851
Harmon Van Dusen, Mineral Point 1852, 1853, 1854
A. L. Castleman, Delafield 1855
John Mitchell, Janesville 1856
D. Cooper Ayres, Green Bay 1857
Clark G. Pease, Janesville 1858, 1859
E. S. Carr, Madison 1860, 1861
Solomon Blood, Rochester 1862

(No meetings held from 1863 through 1866; apparently no new officers).

Harmon Van Dusen, Mineral Point 1867, 1868, 1869
Solon Marks, Milwaukee 1870
H. P. Strong, Beloit 1871
John Favil, Madison 1872
Harmon Van Dusen, Mineral Point 1873
M. Waterhouse, Portage 1874
J. T. Reeve, Appleton 1875
J. B. Whiting, Janesville 1876
J. K. Bartlett, Milwaukee 1877
Darius Mason, Prairie du Chien 1878
Nicholas Senn, Milwaukee 1879
J. G. Meachem, Sr., Racine 1880
Ira Manley, Jr., Markesan 1881
William Meacher, Portage 1882
T. P. Russell, Oshkosh 1883
N. M. Dodson, Berlin 1884
E. W. Bartlett, Milwaukee 1885
G. M. Steele, Oshkosh 1886
S. C. Johnson, Hudson 1887
L. G. Armstrong, Boscobel 1888
J. R. Barnett, Neenah 1889
E. M. Rogers, Hartford 1890
G. D. Ladd, Milwaukee 1891
G. F. Witter, Grand Rapids, Mich. 1892
B. T. Phillips, Menominee, Mich. 1893
B. C. Brett, Green Bay 1894
Almon Clarke, Sheboygan 1895
F. W. Epley, New Richmond 1896
B. O. Reynolds, Lake Geneva 1897
William Mackie, Milwaukee 1898
Herman Reineking, Milwaukee 1899
W. T. Sarles, Sparta 1900
J. F. Pritchard, Manitowoc 1901
W. H. Neilson, Milwaukee 1902
J. V. R. Lyman, Eau Claire 1903
F. E. Walbridge, Milwaukee 1904
C. W. Oviatt, Oshkosh 1905
J. R. Currens, Two Rivers 1906
L. H. Pelton, Waupaca 1907
W. E. Ground, Superior 1908
Gilbert E. Seaman, Madison 1909
Edward Evans, La Crosse 1910
Byron M. Caples, Waukesha 1911
John M. Dodd, Ashland 1912
Arthur J. Patek, Milwaukee 1913
Charles S. Sheldon, Madison 1914
T. J. Redelings, San Diego, Cal. 1915
L. J. Jermain, Milwaukee 1916
Hoyt E. Dearholt, Milwaukee 1917
Gustave Windesheim, Kenosha 1918
D. J. Hayes, Milwaukee 1919
C. R. Bardeen, Madison 1920
H. W. Abraham, Appleton* 1921
M. A. McGarty, La Crosse 1921
S. Hall, Ripon 1922
F. G. Connell, Oshkosh 1923
Rock Sleyster, Wauwatosa 1924
Wilson Cunningham, Platteville 1925
Joseph F. Smith, Wausau 1926
Arthur W. Rogers, Oconomowoc 1927
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Karl W. Doege, Marshfield 1929
F. J. Gaenslen, Milwaukee 1930
A. J. McDowell, Soldiers Grove** 1931
C. A. Harper, Madison 1931
Otho Fiedler, Sheboygan 1932
Reginald H. Jackson, Madison 1933
Stanley J. Seeger, Texarkana, Texas 1934
T. J. O'Leary, Superior 1935
R. M. Carter, Green Bay 1936
Stephen E. Gavin, Fond du Lac 1937
James C. Sargent, Milwaukee 1938
A. E. Rector, Appleton 1939
R. G. Arveson, Frederic 1940
R. P. Sproule, Milwaukee 1941
Gunnar Gundersen, La Crosse 1942
F. E. Butler, Menomonie 1943
R. M. Kurten, Racine 1944
Charles Fidler, Milwaukee 1945
P. R. Minahan, Green Bay 1946
C. A. Dawson, River Falls 1947
W. D. Stovall, Madison 1948
K. H. Doege, Marshfield 1949
J. W. Truitt, Milwaukee 1950
H. H. Christofferson, Colby 1951
A. H. Heidner, West Bend 1952
J. C. Griffith, Milwaukee 1953

* Died during term of office as president-elect.
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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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Milwaukee, Milwaukee Children's (2)
Milwaukee, Milwaukee County (5)
Milwaukee, South View (5)
Monroe, St. Clare (1)
Neenah, Theda Clark Memorial (2)
Oconto, Oconto City & County Hosp. (1)
Oshkosh, Mercy (1)
Plymouth, Plymouth (2)
Racine, St. Luke's (1)
Racine, St. Mary's (1)
Waukesha, Waukesha Memorial (2)
Waupun, Waupun Memorial (2)
Wausau, St. Mary's (1) (*5) (†2)
West Bend, St. Joseph's (1) (*1)
Wild Rose, Wild Rose Hospital (1)

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Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the publ'c.

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**Diseases of Metabolism.** Edited by Garfield G. Duncan, M. D., director of medical division, Pennsylvania Hospital; clinical professor of medicine, Jefferson Medical College, Philadelphia, Pa. Third edition. Philadelphia, W. B. Saunders Company, 1952.

An effort is made in this work to approach the clinical aspects of metabolic disease through an understanding of the fundamental medical sciences. A surprisingly complete treatment of carbohydrate, lipid, protein, mineral, and vitamin metabolism occupies the first half of the book, while the remaining half deals with specific disease entities in which disordered metabolism is primarily implicated. The many contributing authors are well-recognized authorities in their respective fields.

The sections on carbohydrate metabolism, by Doctors Soskin and Levine, and the section on water balance, by Doctor Peters, have been extensively revised. These two subjects are particularly well presented in the careful and lucid style characteristic of these authors. Dr. Cecil Watson has added a much needed section on porphyrin metabolism. This probably represents the most definitive presentation of this subject available to the clinician.

Despite the excellence of its material, it is difficult to decide to whom this work should be recommended. Since it does not contain exhaustive coverages of any subject, it cannot be considered a source book. Although it is the aim of the editor to "bridge the gap" between the investigator and the clinician, few of the latter will feel it practical to search this extensively into the mechanisms of disease. The practicing internist, on the other hand, might find it of value in keeping abreast of current or near-current concepts in basic medical sciences with a minimum expenditure of time.—F.C.L.

**The Low Fat Diet Cook Book.** By Dorothy Myers Hildreth, dietician, and Eugene A. Hildreth, M. D. New York, Medical Research Press, 1952. Price, $2.95.

The introduction to *The Low Fat Diet Cookbook* states that there are "many who believe that the evidence being assembled warrants restrained optimism" over the value of a low fat diet in reducing the incidence of atherosclerosis. "Yet many physicians are now suggesting to their older patients . . . that they reduce their intake of fatty foods."

*The Low Fat Diet Cook Book* is essentially what the title describes—a cook book. It describes many ways of introducing flavor and variety into a low fat diet. As the authors point out, fats add a great amount of flavor to foods. When no fats are added in cooking, other flavor ingredients must be used if one wishes to produce foods with appetite appeal.

The recipes for meats, vegetables, and desserts are extremely interesting. It is improbable, however, that all the prepared meat dishes would be low in fat content, since many of them make no mention of removing the collected fat drippings from the browned meats before adding the other ingredients. Foods particularly high in cholesterol are mentioned, and egg yolks and fats are generally avoided in the recipes.

The fat content of representative foods is listed and sample menus are given. Unfortunately no general menu pattern is presented for planning menus to meet National Research Council recommended allowances in spite of fat restriction.

For a patient with plenty of free time who wishes a high calorie but low fat diet, the book provides a variety of interesting recipes.—R.S.D.

**Nutrition and Diet in Health and Disease.** By James S. McLester, M. D., professor of medicine emeritus, University of Alabama; and William J. Darby, M.D., Ph.D., professor of biochemistry and director of the division of nutrition, Vanderbilt University. Sixth edition. Philadelphia, W. B. Saunders Company, 1952.

The present edition of *Nutrition and Diet in Health and Disease* brings up to date the subject matter presented in earlier versions of this book. Particularly noteworthy are the changes concerning the vitamins, low-sodium regimen for hyperten-

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General Surgery, Two Weeks, starting April 26
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Basic Principles in General Surgery, Two Weeks, starting March 29

GYNECOLOGY—Intensive Course, Two Weeks, starting February 15
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sion, treatment of anemias, and the new system of dietary equivalents for the planning of diabetic diets. The general organization of the book remains the same. The book is recommended for reference purposes.—E.C.A.

**The Literature on Streptomycin, 1944–1952.** By Selman A. Waksman. Second edition. New Brunswick, N. J., Rutgers University Press, 1952. Price, $5.00.

Similar in form to the first, this second edition contains a list of all of the references on streptomycin discovered by the author. The search was painstaking. The number of references increased from nearly 1,200 to nearly 6,000 in the four years between the two editions. Papers reporting clinical investigations are numerous. Many abstracts and preliminary reports are listed, even though they have not been published in complete form.

The first section of the book contains a group of important papers designated by Roman numerals: I to XII cover important studies on Actinomyces as a group; XIII to XXIV deal with the production of antibiotic substances by Actinomycetes. Then 19 papers are noted which concern streptothricin, the isolation and knowledge of which preceded that of streptomycin. The main section follows and is a chronological list of all publications on streptomycin which have been discovered. Arabic numbers are used. The last section contains an index to authors and a very comprehensive subject index, revised extensively for this edition. References can be found to specific aspects pertinent to the subject, but secondary and incidental to the purpose of the paper listed. Sources of such information might have been buried under general headings. Because of the practical and detailed arrangement of the subject index, and the comprehensive documentation of publications, this work will be of immense value to anyone who must quickly and with confidence explore the sources of available knowledge about streptomycin. —J.W.B.

**Gynecologic and Obstetric Pathology.** By Emil Novak, A. B., M. D., D. Sc. (Hon., Trinity College, Dublin; Tulane), F.A.C.S., F.R.C.O.G. (Hon.), Assistant professor emeritis of gynecology, The Johns Hopkins Medical School; gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore; fellow and past president, American Gynecological Society. Third edition. Philadelphia, W. B. Saunders Company, 1952. Price, $10.00.

This new third edition of *Gynecologic and Obstetric Pathology* has been completely revised. Each chapter contains an up-to-date bibiliography. An excellent chapter on the common breast lesions of interest to the gynecologist has been added.

This is the outstanding book in the English language in this field. It will be of great benefit to the medical student and also will be used as a standard reference book by the experienced pathologist. —M.J.T.

**The Principles and Methods of Physical Diagnosis.** By Simon S. Leopold, M.D., associate professor of clinical medicine, School of Medicine and Graduate School of Medicine, University of Pennsylvania; director of the teaching of physical diagnosis, School of Medicine; chief of the Thoracic Clinic, Hospital of the University of Pennsylvania. Philadelphia, W. B. Saunders Company, 1952.

To those familiar with the older *Diseases of the Chest and the Principles of Physical Diagnosis* by Norris and Landis, this text will seem like an old friend. The similarity is legitimate, for Doctor Leopold was co-author of the most recent edition of that text. From it he has borrowed many of the finer features, including the classic anatomic sections used to illustrate the bases of physical findings and the fundamental approach that "the principles and methods of physical diagnosis should be taught by correlating physical signs with physiologic and pathologic changes in disease." Emphasis has been placed primarily upon examination and findings, the somewhat inadequate descriptions of clinical disease having been for the most part eliminated. In addition to the cardiovascular and respiratory systems, the text has been expanded to include the entire physical examination, with detailed data referable to such features as the examination of the musculoskeletal system, the male and female genital systems, and the nervous system. The entire book has been streamlined and brought entirely up to date. The black-and-white illustrations are of excellent quality and a good many quite useful colored plates have been added. It is true that the book is written primarily as a text, and it is an excellent one, but the practicing physician who is constantly striving to improve his technics and abilities will find much here that is of value to him. The book can be recommended as a reference work for any physician's shelf.—J.L.S.

**Signs and Symptoms, Applied Pathologic Physiology and Clinical Interpretation.** Edited by Cyril M. MacBryde, A.B., M.D., F.A.C.P., associate professor of clinical medicine, Washington University School of Medicine; assistant physician, the Barnes Hospital; director, Metabolism and Endocrine Clinics, Washington University Clinics, St. Louis, Mo. Second edition. Philadelphia, J. B. Lippincott Company, 1952. Price, $10.00.

In each day's practice the physician repeatedly must attempt to explain the symptoms presented by his patients. When diagnostic uncertainty sends him to his books, he finds limited help in the long indices of nosologic entities. The text lists intracranial neoplasms, labyrinthitis, or bacterial endocarditis, but the patient unobligingly complains merely of headache, dizziness, or fever. In *Signs and Symptoms* each of these and many of the other common manifestations of disease have been searchingly analyzed as to their mechanisms and circumstances of occurrence. Sore mouth, backache, cough, jaundice, fainting, and edema are among the other conditions which are evaluated. Each of the 26 collaborating authors is widely recognized in his field. Their essays are clearly and simply written in all but a


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few instances, and the realities and limitations of the office and bedside have been kept constantly in mind. Either as a quick reference to point the way to diagnostic possibilities during the day's practice or for contemplative reading at home this book should prove a valuable addition to any physician's library.—J.L.S.

**Synovial Fluid Changes in Joint Disease.** By Marian W. Ropes, M.D., associate physician, Massachusetts General Hospital; assistant clinical professor of medicine, Harvard Medical School; and Walter Bauer, M.D., chief of medical services, Massachusetts General Hospital; Jackson professor of clinical medicine and director of Robert W. Lovett Memorial Foundation for the study of crippling disease, Harvard Medical School. Cambridge, Mass., published for the Commonwealth Fund, Harvard University Press, 1953. Price, $4.00.

A definitive study of joint fluid has been long awaited. This volume is the result of 20 years of study of joint fluid in health and disease. Over 1,500 examinations of synovial fluids of patients with various joint diseases have been obtained, and the fluid has been described and analyzed.

The book opens with a discussion of normal synovial fluid. The method of obtaining the fluid, the gross examination, and the bacteriologic and the cytologic examinations are described. Physical and chemical data are given.

Presented next are the variations in the characteristics of synovial fluid in disease and the findings in fluids in two specific groups—those in diseases of traumatic origin and those in rheumatoid arthritis and in diseases of infectious origin. In the discussion of the various characteristics of synovial fluids in disease, the authors present the changes on administration of sulfonamides, penicillin, and Chloromycetin.

The changes in the clinical entities of traumatic origin are described for traumatic arthritis, osteochondritis dissecans, osteochondromatosis, Charcot's joints, and degenerative joint diseases in the aged. Included in the discussion of synovial fluid changes in diseases of infectious origin are gonococcal arthritis, meningococcal arthritis, septic joints, rheumatoid arthritis, intermittent hydrarthrosis, bursitis, Baker's cysts, and others.

The diagnostic value of joint aspiration is discussed. The volume ends with a discussion of the physiologic considerations of the findings. An excellent bibliography is contained in the volume. A large table designed to facilitate diagnosis summarizes the results of this study and is of definite value. This book is a milestone in the study of joint diseases.—H.W.W.

**Operating Room Technic.** St. Mary's Hospital, Rochester, Minn. Fourth edition. Philadelphia and London, W. B. Saunders Company, 1952.

This book gives the surgical nurse's set-up, including position, draping, instruments, drains, sutures, and a well-illustrated description of the surgical procedure for many of the operations performed at St. Mary's Hospital, Rochester, Minn. These include operative procedures in general and procedures for orthopedic, neurologic, and urologic surgery. There are also short chapters on procedure in peroral endoscopy and block anesthesia. Difficulty that might be encountered as a result of variations in terminology is avoided by generous use of illustrations of basic set-ups, individual procedures, and an index of illustrated instruments.

Operating room nurses will find this book useful as a reference in preparing their own cards. It is a convenient source of descriptions of many surgical procedures as performed by the Mayo Clinic staff. —W.P.Y.

**Gifford's Textbook of Ophthalmology.** By Francis Heed Adler, M.D., professor of ophthalmology, University of Pennsylvania Medical School; consulting surgeon, Wills Eye Hospital, Philadelphia. Fifth edition. Philadelphia, W. B. Saunders Company, 1953.

The fifth edition of *Gifford's Textbook of Ophthalmology* by Adler is probably the finest small text on this subject. Ophthalmic progress has been so rapid that frequent new editions to cover the field are necessary. The text is especially suited to the needs of students and general practitioners. Indeed, the best-

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The Medical Clinics of North America. Philadelphia, W. B. Saunders Company, 1952.

The November 1952 number of *The Medical Clinics of North America* is a symposium devoted to pediatric problems. It consists of 28 papers by men and women of Philadelphia medical centers who are authorities in their various fields. A wide selection of subjects of interest to the general practitioner and pediatrician has been covered in comparatively short, but very informative and practical articles. This Clinic is highly recommended to the busy practitioner.—K.B.M.

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WANTED: As an associate with subsequent partnership arrangement, a young man who is interested in the great challenge of general practice. Interesting growing community 30 miles from Madison. Resort during summer with 6 lakes in area. New modern office with up-to-date facilities and equipment. Hospital near by with open staff privileges. Please address letters to Box 497 in care of the Journal.

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| Barron-Washburn-Sawyer-Burnett | W. F. Vaudreuil<br>Rice Lake | D. F. Hammond<br>Chetek | Second Tuesday<br>7:30 p.m. |
| Brown-Kewaunee-Door | G. B. Merline<br>De Pere | G. M. Shinners<br>409 E. Walnut<br>Green Bay | Second Thursday* |
| Calumet | F. P. Larme<br>New Holstein | J. M. Guthrie<br>Brillion | |
| Chippewa | C. A. Kemper<br>119½ Bridge<br>Chippewa Falls | Paul Murphy<br>Bloomer | Second Tuesday |
| Clark | K. F. Manz<br>Neillsville | J. W. Koch<br>Colby | |
| Columbia-Marquette-Adams | R. F. Inman<br>Montello | E. G. Nafziger<br>Oxford | Second Tuesday<br>7:00 p.m. |
| Crawford | R. G. Konicek<br>Prairie du Chien | H. L. Shapiro<br>Prairie du Chien | |
| Dane | S. L. Chase<br>905 University Ave.<br>Madison | G. E. Oosterhous<br>304 W. Washington<br>Madison | Second Tuesday |
| Dodge | Leonard Schrank<br>Waupun | R. F. Boock<br>119½ Front<br>Beaver Dam | Last Thursday* |
| Douglas | F. G. Johnson<br>1507 Tower<br>Superior | F. W. Reibold<br>1574 Ogden<br>Superior | First Wednesday**<br>Badger Room of the<br>Hotel Superior |
| Eau Claire-Dunn-Pepin | W. G. Cameron<br>131 S. Barstow<br>Eau Claire | H. E. Sorensen<br>314 E. Grand<br>Eau Claire | Last Monday |
| Fond du Lac | W. H. Schuler<br>Ripon | H. J. McLane<br>80 Sheboygan St.<br>Fond du Lac | Fourth Thursday* |
| Forest | O. S. Tenley<br>Wabeno | D. V. Moffet<br>Crandon | |
| Grant | J. L. Moffett<br>Platteville | H. W. Carey<br>Lancaster | Last Thursday.<br>March, June,<br>Sept. and Nov. |
| Green | N. E. Bear<br>Monroe | D. E. Mings<br>Monroe Clinic<br>Monroe | |
| Green Lake-Waushara | Russell Pelton<br>Markesan | L. S. Shemanski<br>Wautoma | Last Thursday,<br>every other month<br>starting in Jan. |
| Iowa | C. L. White<br>Mineral Point | H. M. Walker<br>Dodgeville | First Thursday<br>following<br>first Monday |
| Jefferson | O. H. Hanson<br>9 S. Water<br>Fort Atkinson | H. N. Hunsader<br>111 S. Main<br>Fort Atkinson | Third Thursday* |

* Except June, July, and August.
** Except July and August.

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## List of Officers and Scheduled Meetings of County Medical Societies—Continued

| COUNTY | PRESIDENT | SECRETARY | MEETING DATE |
|---|---|---|---|
| Juneau | J. S. Hess<br>Mauston | John E. Thompson<br>Mauston | Second Tuesday<br>Hess Clinic in<br>Mauston |
| Kenosha | Richard M. Block<br>520 58th<br>Kenosha | Helen A. Binnie<br>7609 25th<br>Kenosha | First Thursday*<br>Elks Club<br>Kenosha |
| La Crosse | C. F. Midelfort<br>1836 South Ave.<br>La Crosse | Arnold A. Cook<br>1707 Main<br>La Crosse | Third Monday |
| Lafayette | N. A. McGreane<br>128 E. Ann St.<br>Darlington | R. E. Oertley<br>Darlington | Last Tuesday |
| Langlade | D. W. Dalley<br>Elcho | F. H. Garbisch<br>Antigo | Second Wednesday |
| Lincoln | Walter Lewinnek<br>700 E. Third<br>Merrill | J. D. Millenbah<br>Merrill | |
| Manitowoc | W. H. Scherping<br>817 S. Eighth<br>Manitowoc | D. M. Pick<br>926 Eighth<br>Manitowoc | Last Thursday |
| Marathon | H. W. Christensen<br>501½ Third<br>Wausau | J. M. Foerster<br>1024 Steuben<br>Wausau | |
| Marinette-Florence | J. W. Boren<br>1510 Main<br>Marinette | R. J. Rogers<br>Oconto | Third Wednesday<br>St. Joseph's Hospital |
| Milwaukee | J. G. Garland<br>324 E. Wisconsin<br>Milwaukee | Donald M. Willson<br>324 E. Wisconsin<br>Mr. J. O. Kelley, Ex. Sec.<br>208 E. Wisconsin | Second Thursday |
| Monroe | C. E. Kozarek<br>Tomah | J. S. Mubarak<br>Tomah | Third Monday |
| Oconto | F. E. Zantow<br>Oconto | G. R. Sandgren<br>Suring | |
| Oneida-Vilas | G. R. Thuerer<br>1020 Kabel<br>Rhinelander | Marvin Wright<br>1020 Kabel<br>Rhinelander | Monthly |
| Outagamie | W. S. Giffin<br>601 W. College<br>Appleton | F. J. Rankin<br>214 E. Wisconsin<br>Appleton | Third Thursday*<br>Elks Club<br>6:30 p.m. |
| Pierce-St. Croix | P. W. Limberg<br>Glenwood City | P. H. Gutzler<br>River Falls | Third Tuesday |
| Polk | H. A. Dasler<br>Cornwall Clinic<br>Amery | L. J. Weller.<br>Osceola | Third Thursday<br>7 p.m. |
| Portage | V. A. Benn<br>Rosholt | H. A. Anderson<br>Stevens Point | |
| Price-Taylor | J. L. Rens<br>Phillips | J. J. Leahy<br>Park Falls | Last Saturday,<br>Feb., May, Aug.,<br>and Nov. |
| Racine | G. L. Rothenmaier<br>3115 Washington Ave.<br>Racine | Eugene Pitts<br>420 Seventh<br>Racine | Third Thursday |
| Richland | W. C. Edwards<br>Richland Center | L. M. Pippin<br>Richland Center | First Tuesday<br>Richland Hospital |
| Rock | Milton Davis<br>Milton | H. M. Snodgrass<br>508 W. Milwaukee<br>Janesville | Fourth Tuesday |
| Rusk | L. M. Lundmark<br>Ladysmith | M. L. Whalen<br>Bruce | First Tuesday |
| Sauk | O. V. Pawlisch<br>Reedsburg | J. J. Rouse<br>Reedsburg | Second Tuesday* |
| Shawano | R. C. Cantwell<br>Shawano | A. J. Sebesta<br>Shawano | Third Tuesday |
| Sheboygan | J. W. McRoberts<br>1011 N. Eighth<br>Sheboygan | H. J. Winsauer<br>1011 N. Eighth<br>Sheboygan | First Thursday |
| Trempealeau-Jackson-Buffalo | O. M. Schneider<br>Blair | E. P. Rohde<br>Galesville | Fourth Tuesday |
| Vernon | L. F. Gulbrandsen<br>Viroqua | DeVerne W. Vig<br>Viroqua | Last Wednesday |
| Walworth | Laird McNeel<br>Genoa City | G. O. Truex<br>Darien | Second Thursday* |
| Washington-Ozaukee | T. D. Ebe<br>Thiensville | F. I. Bush<br>West Bend | Fourth Thursday |
| Waukesha | Peter Theobald<br>Oconomowoc | F. A. Thompson<br>725 American Ave.<br>Waukesha | |
| Waupaca | J. H. Steiner<br>201 N. Main<br>Waupaca | W. R. McInnis<br>Marion | |
| Winnebago | B. S. Greenwood<br>19 Jefferson Ave.<br>Oshkosh | G. B. Hildebrand<br>216½ Main<br>Menasha | First Thursday |
| Wood | J. S. Vedder<br>Marshfield | R. W. Mason<br>Marshfield | Four times a year |

* Except June, July, and August.

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# Aortography and Pneumography*

By WALTER M. KEARNS, M. D.
Milwaukee

TRANSLUMBAR abdominal aortography and presacral pneumography are used separately or in combination. They complement each other and in turn complement previous urographic and other tests, augmenting and supporting the routine examinations. This review of a series of 45 patients is presented with the idea of stimulating wider use of these procedures.

Aortography and pneumography have been reserved in this series for patients about whom added information was desired in order to clinch a diagnosis. To our surprise, conditions not anticipated were unearthed in a number of instances. Several mishaps and failures occurred to impress upon us the importance of certain points in technic.

Fig. 1.—Horseshoe kidney. Demonstration of parenchymal isthmus and blood supply originating from the aorta to all parts of the kidney.

Fig. 2—Trauma of the left kidney sustained in a football game by a 19-year-old boy. The oxygen injection in the presacral region outlines a normal right kidney and imperfectly outlines the traumatized left kidney. The arteriogram of the right kidney is normal throughout. The left filling is dispersed at the lower pole as a result of contusion and hemorrhage.

## Aortography

A halo of respect surrounding the aorta remained inviolate until it was penetrated by Dos Santos,[1,2] who published his results in 1929 and 1931. Through a long needle he injected an opaque medium into the great artery to demonstrate the abdominal arterial circulation and thereby introduced a proce-

*Presented at Chicago Urological Society, Chicago, Ill., Dec. 11, 1952.

dure with widespread possibilities for aiding diagnosis. In 1936 Henline and Moore[3] reported mixed results in their experimental aortograms in dogs. Some unsatisfactory results they had were due to the known toxicity of iodides when given in massive doses of concentrated solutions. Nelson,[4] who in 1942 reported satisfactory results, was the first among American urologists to apply aortography clinically. A few years later, Doss[5] enthusiastically advocated the use of aortography as an aid in urologic diagnosis and especially in estimating renal function as a guide to conservative surgery. Recently Smith,[6] in reporting over 1,000 injections, offered corroborating evidence of its value and safety. Poutasse, Engel, and Root,[7] reporting over 100 injections, attest to the safety and value of the procedure and point out its possibilities in extra-urinary conditions. Goodwin, Scardino, and Scott[8] compare the method of femoral artery catheterization with the translumbar needle injection and prefer the latter.

The technic described by Smith has been used with a few modifications. Under Pentothal Sodium anesthesia the translumbar aortic injection is made by inserting the special No. 16 needle, 15 cm. in length, into the lumbar region at a point four fingerbreadths lateral to the midline and 1 cm. below the twelfth rib on the left side. The needle tip meets the twelfth dorsal vertebral body, is withdrawn a short distance, and is then directed more anteriorly to enter the aorta. Neo-Iopax** is the opaque medium of choice because of its minimal toxicity and freedom from untoward reactions, based on a comparison with the other commonly used media in intravenous urography. An injection of 15 to 20 cc. of 75 per cent solution is rapidly made from a 50 cc. syringe, with x-ray exposure just before the end of the injection. The follow-through or continuance of the injection until after the x-ray exposure is completed is most essential, as the opaque medium is so rapidly swept away in the aorta that any hesitation or slowing of the rate of injection makes a good aortogram impossible. The cir-

Fig. 3—Tortuous aorta and aneurysm of the splenic artery. The patient complains of upper left quadrant pain.

Fig. 4—Agenesis of the left kidney and ectopic pelvic right kidney with blood supply from the right common iliac artery.

**Supplied by Clinical Research Division of Schering Corporation, Bloomfield, N. J.

culation in the arteries of the legs is momentarily arrested by inflation of cuffs placed at a level just above the knees. X-ray exposure of one tenth of a second at 200 ma. and 70 kv. is the usual technic, to be varied according to the size of the patient.

The safety previously well established by others was corroborated by the absence of any major ill effects. No evidence of aortic leakage was found when injected areas were inspected at operation, 24 to 48 hours after injection. X-rays have proved that if extravasation of Neo-Iopax occurs as a result of penetration of the aorta by the needle, absorption occurs within a few hours. There are no residual effects, other than local discomfort or lameness lasting 24 to 48 hours.

### Pneumography

The presacral pneumogram, which outlines the kidneys, adrenals, and other organs, was first described by Ruiz Rivas[9] in 1950. A technic essentially similar to his has been applied in this series. Under local anesthesia, 400 cc. of oxygen is injected through a No. 18 spinal puncture needle which has been inserted at a point 2 cm. lateral to the sacrococcygeal joint and directed to the midline in the presacral and postrectal tissue. The injection is usually made one-half hour before pyelography or aortography. The oxygen ascends to the level of the diaphragm in a few moments. Blackwood,[10] of Melbourne, Australia, has modified the technic to make the injection just posterior to the anus.

### Discussion

The diagnostic value of aortography lies in the fact that it reveals significant changes in the arterial pattern. An aortogram can be particularly helpful, for example, in differentating between a tumor and a cyst—a question that a pyelographic outline does not answer, for it shows simply a space-filling defect that might indicate the presence of either a tumor or a cyst. If a cyst is present, an aortogram shows a lack of vascularity in the region; if a tumor is present, the aortogram shows an increased density and usually an enlarged nutrient artery to the area and laking of iodic substance in the mass of the tumor as well. In traumatized kidneys the normal arborization of the blood supply is disturbed or absent, and pooling of iodic shadow in the region of the hemorrhage is often a telltale as to the location and extent of the injury. The decision whether to perform radical surgery or to follow a conservative course is determined in many instances by the appearance of the blood supply. In hypertension where unilateral renal disease exists, the demonstration of a limited or atrophic blood supply to the involved kidney fortifies one's position or decision in regard to removing the kidney. Renal anomalies of the organs and their blood supply are demonstrated with precision by means of aortography. To the surprise of the examiner, aneurysm of various branches of the aorta has been demonstrated. The location and extent of arteriovenous fistulae have been demonstrated accurately. In pregnancy the placenta may be accurately located and knowing its location has been helpful in the identification of placenta praevia.

Aortography brought to light the following conditions in this series of patients:

| | | | |
|---|---|---|---|
| Renal tumor | 4 | Aortic coarctation | 2 |
| Agenesis | 3 | Horseshoe kidney | 2 |
| Dystopia | 3 | Renal vein varix | 1 |
| Renal cyst | 3 | Adrenal calcification | 1 |
| Pyelonephritis | 2 | Adrenal cyst | 1 |
| Nephrosclerosis | 2 | Perinephric abscess | 1 |
| Abdominal aneurysms | 2 | Polycystic condition | 1 |
| Renal trauma | 2 | Calcified renal artery | 1 |

The use of the presacral pneumogram, of course, aided in the identification of a number of the conditions.

The most common complaints have been of occasional backache and shoulder pain. In no case did these reactions last more than 24 hours.

### Conclusions

Abdominal aortography and presacral pneumography were helpful aids in diagnosis in 45 selected patients. No harmful effects attended the procedures.

The author has increased the series to over 100 since presentation.

238 West Wisconsin Avenue.

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## SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1953, the March of Medicine began its eighth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 39 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

| *Station* | *City* | *Time* | |
|---|---|---|---|
| WHBY | Appleton | Saturday | 8:30 a.m. |
| WATW | Ashland | Saturday | 8:15 a.m. |
| WHSA | Brule | Saturday | 10:30 a.m. |
| WHKW | Chilton | Saturday | 10:30 a.m. |
| WHWC | Colfax | Saturday | 10:30 a.m. |
| WHAD | Delafield | Saturday | 10:30 a.m. |
| WEAU | Eau Claire | Saturday | 1:30 p.m. |
| KFIZ | Fond du Lac | Saturday | 8:30 a.m. |
| WBAY | Green Bay | Saturday | 3:15 p.m. |
| WHHI | Highland | Saturday | 10:30 a.m. |
| WJMS | Ironwood, Michigan | Saturday | 8:15 a.m. |
| WLIP | Kenosha | Saturday | 11:15 a.m. |
| WKBH | La Crosse | Saturday | 11:00 a.m. |
| WLDY | Ladysmith | Saturday | 11:00 a.m. |
| WHA | Madison | Saturday | 10:30 a.m. |
| WIBA | Madison | Saturday | 9:00 a.m. |
| WOMT | Manitowoc | Saturday | 9:15 a.m. |
| WMAM | Marinette | Saturday | 11:45 a.m. |
| WDLB | Marshfield | Saturday | 10:45 a.m. |
| WIGM | Medford | Saturday | 10:15 a.m. |
| WCAN | Milwaukee | Sunday | 6:45 p.m. |
| WEKZ | Monroe | Friday | 2:00 p.m. |
| WNAM | Neenah | Wednesday | 8:45 a.m. |
| WPFP | Park Falls | Saturday | 10:45 a.m. |
| WIBU | Poynette | Thursday | 2:30 p.m. |
| WPRE | Prairie du Chien | Saturday | 10:15 a.m. |
| WRJN | Racine | Sunday | 5:45 p.m. |
| KAAA | Red Wing, Minnesota | Monday | 9:15 a.m. |
| WRDB | Reedsburg | Monday | 4:15 p.m. |
| WOBT | Rhinelander | Saturday | 9:15 a.m. |
| WHRM | Rib Mountain | Saturday | 10:30 a.m. |
| WJMC | Rice Lake | Saturday | 10:00 a.m. |
| WRCO | Richland Center | Wednesday | 3:30 p.m. |
| WTCH | Shawano | Sunday | 6:45 p.m. |
| WHBL | Sheboygan | Tuesday | 7:15 p.m. |
| WLBL | Stevens Point | Saturday | 10:30 a.m. |
| WDOR | Sturgeon Bay | Thursday | 9:15 a.m. |
| WDSM | Superior | Saturday | 10:15 a.m. |
| WSAU | Wausau | Monday | 4:15 p.m. |
| WBKV | West Bend | Saturday | 11:00 a.m. |
| WHLA | West Salem | Saturday | 10:30 a.m. |

# Translumbar Aortography

By JAMES M. SULLIVAN, M. D., THEODORE J. PFEFFER, M. D., and ROBERT A. FRISCH, M. D.*

Milwaukee

TRANSLUMBAR aortography has been used for the past two decades to study renal pathology, but its use as a diagnostic tool in peripheral arterial disease is fairly recent and has become popular only in the past few years.[1-5]

In the treatment of patients with arteriosclerosis obliterans it is an extremely useful tool in determining the location and extent of the arteriosclerotic process. It is also of great value in determining the exact site of an aneurysm, especially when surgical correction is contemplated. Lovingood and Patton also advocate its use in determining the exact site of peripheral emboli before removal.[6]

Our experience with aortography dates back to 2 years ago when we began to use it as a diagnostic aid in the Peripheral Vascular Clinic at the Veterans Hospital, Wood. It has enabled us to diagnose peripheral vascular disease more accurately; and since we now can treat aneurysms and segmental obstructions by vascular grafts, the more exact localization is an aid to the surgeon. Using aortography postoperatively is also valuable in determining the efficacy of the treatment rendered.

Figure 1 is a drawing outlining the technic of doing a translumbar aortogram. We routinely test the patients for iodine sensitivity and give them a routine cleansing preparation of the colon. The patient is then placed prone on the radiographic table and anesthetized with pentothal intravenously, and a sterile preparation of the skin is done. A No. 18 gauge needle, approximately 15 cm. in length, is inserted in the left paravertebral soft tissues approximately 7.5 cm. from the midline and just below the lower border of the left twelfth rib. The needle is angulated medially and 45 degrees toward the patient's head and pushed into the aorta at the level of the body of the twelfth thoracic vertebra. For adults, 12 to 40 cc. of 70 per cent Urokon or Neo-Iopax is used. The injection is made as rapidly as possible, and the x-ray exposure is made just before the syringe is emptied. A flexible plastic hose connection between the needle and syringe allows the operator's hands to be outside of the field of exposure.

Translumbar aortography has been used in 20 of our patients where information was sought about the abdominal aorta or its branches to the legs. The following 6 case reports will serve to illustrate some of our experiences with the procedure, its usefulness, and its limitations.

## CASE REPORTS

### Case 1. Normal Abdominal Aortic Angiogram

A.P.W., a 52-year-old male was admitted to the hospital on May 21, 1952.

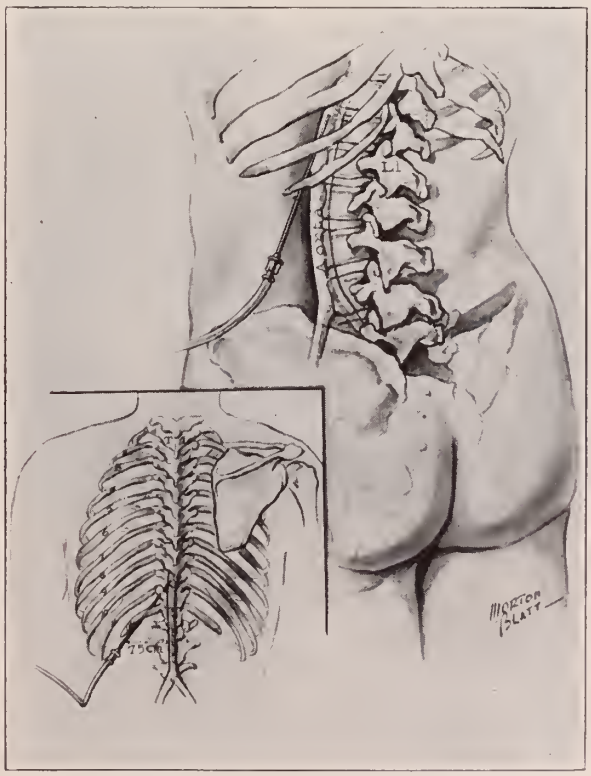


Fig. 1—Technic of translumbar aortography.

* From the Peripheral Vascular Disease Clinic, Veterans Administration Hospital, Wood, and Marquette University School of Medicine.

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*Entrance Complaint.* Cramps in legs upon exercise. Cold feet.

*Physical Examination.* (1) Essentially normal blood pressure. (2) Diminished oscillometric readings, both legs. (3) Absent arterial pulsation in posterior tibials and dorsalis pedis, bilaterally.

*Procedure.* Lumbar aortic angiogram. Essentially normal abdominal aorta and femoral vessels.

*Treatment.* Patient received bilateral lumbar sympathectomy.

*Results.* Marked subjective improvement.

*Comment.* Figure 2 is the aortogram in this case. The iliac vessels and femoral vessels are visualized very well and confirm the patency of the large vessels of the legs in this patient. Since there was still no objective diminution in size of the large vessels in this particular case, we would expect considerable improvement from sympathectomy.

Fig. 2—Normal abdominal aortic angiogram.

### Case 2. Complete Occlusion of Right Iliac Artery

A 61-year-old male was admitted to the hospital on May 29, 1952.

*Entrance Complaint.* Cramplike pains in both legs, aggravated by exercise, relieved by rest and elevation, increasing in severity over the past 4½ years.

Fig. 3—Complete occlusion of right iliac artery.

*Physical Examination.* (1) Blood pressure 160/110. (2) Absent arterial pulsations below the knees in both legs. (3) Venous varicosities, legs, bilateral. (4) Oscillometric readings markedly reduced, both legs, particularly on right. (5) Marked calcification of thoracic aorta shown by chest x-ray.

*Procedure.* Lumbar aortic angiogram (Fig. 3) shows a complete occlusion of the right iliac artery. The left iliac artery was patent.

*Treatment.* The patient was given a bilateral lumbar sympathectomy with questionable benefit on the right leg and marked improvement on the left leg.

*Comment.* The aortograms confirmed the prognosis in this case and indicated that a very poor result could be expected on the right side. Since we could not visualize the femoral vessel on the right, a vascular graft was not considered because the artery could not be visualized distal to the block.

### Case 3. Complete Abdominal Aortic Occlusion

C.L.B., a 54-year-old male, was admitted to the hospital on October 16, 1951.

*Entrance Complaint.* (1) Numbness in lower extremities during past 3 months. (2) Coldness over entire lower extremities.

(3) Loss of motor control of legs. (4) "Tired pain" in both legs for 3 months.

*Physical Examination.* (1) Blood pressure 130/80. (2) Absent arterial pulse in all vessels in both lower extremities, including femorals. (3) Abdominal aortic pulse only above umbilicus. (4) Roentgenogram of abdomen showed marked calcification of aorta with probable aneurysm at L–3—L–4.

*Procedure.* Lumbar aortic angiogram (Fig. 4) shows complete occlusion of the abdominal aorta at the level of L–1, 1.5 cm. below the renal artery. This aneurysm had undoubtedly obliterated itself by spontaneously clotting.

*Treatment.* A bilateral lumbar sympathectomy was performed. This increased the collateral blood supply and gave the patient symptomatic relief.

Fig. 4—Complete abdominal aortic occlusion.

### Case 4. Abdominal Aneurysm

R.W., colored male, 43 years of age.

*Entrance Complaint.* Para-umbilical pain radiating into the scrotum.

*Past Medical History.* Central nervous system lues with tabes and blindness. History of hypertension of several years' duration.

*Physical Examination.* (1) Objective findings indicating tabes dorsalis. (2) Optic atrophy. (3) Pulsating mass in the left side of the abdomen. (4) Blood pressure 184/116. (5) Left femoral pulsation diminished. (6) Oscillometric index low in the left lower extremity.

*Procedure.* Abdominal aortogram (Fig. 5) shows an aneurysm of the abdominal aorta from the level of the celiac axis down to and involving the left common iliac artery. Some involvement of the thoracic aorta, too high to permit wrapping, was also shown.

*Treatment.* No treatment was attempted in this instance because of the extent of the aneurysm, which would contraindicate direct surgery.

Fig. 5—Abdominal aneurysm.

### Case 5. Right Iliac Arterial Embolus

C.B., 59 years of age, was admitted to the hospital on May 29, 1953.

*Entrance Complaint.* Because of increasing signs of heart failure, the patient entered the hospital several weeks after myocardial infarction. Blood pressure on admission was 135/80. Electrocardiograms showed anteroseptal myocardial infarction and auricular fibrillation.

*Course in Hospital.* The auricular fibrillation was converted to sinus rhythm with quinidine therapy, and the patient's condition improved slightly. However, on June 5 an embolism occurred to the right leg.

*Procedure.* The aortogram (Fig. 6) showed a block of the right external iliac artery just beyond the bifurcation. An abdominal exploration was done and the right iliac artery was found to be pulsating normally. An incision was then made into the femoral artery and the embolus in the upper third found and removed. A free flow of blood through the artery resulted. The patient probably had a mild cerebrovascular accident during surgery. Anticoagulants were discontinued after surgery because of the abdominal wall bleeding. The right leg showed demarcation on the fifth postoperative day and was placed in refrigeration. On June 24 a right mid-thigh amputation was done.

*Comment.* Manipulation of the patient during the procedure of aortography may have been responsible for the descent of the clot from the right iliac into the femoral artery. Spasm is another possible explanation of the discrepancy between the findings at operation and on aortography. Had the patient been on the operating table during aortography and had he been handled more gently, this accident may not have occurred.

Fig. 6—Right iliac arterial embolus.

Fig. 7—Occlusion of the right common iliac artery

### Case 6. Occlusion of the Right Common Iliac Artery

G.E.T., white male, 53 years of age.

*Entrance Complaint.* Pain in right foot.

*Past Medical History.* The patient first had pain in his right first toe in 1951, following exposure to below zero weather. He was hospitalized for 10 days at that time with diagnosis of localized cellulitis, right first toe. He was treated satisfactorily with warm packs. He had a similar complaint in January 1953, with five-day hospitalization. He was admitted to the hospital August 27, 1953, with complaint of severe, throbbing pain in his right first toe, extending upward over the entire right thigh. An examination showed a small necrotic ulcer 1.5 cm. in diameter on the medial aspect of the right first toe, with an area of cellulitis over the medial aspect of the forefoot.

*Physical Examination.* General examination by systems essentially negative except for the following: (1) Blood pressure 156/108. (2) Absent arterial pulsation over entire right lower extremity. (3) Oscillometric Index (Collens Oscillometer) a. Zero over entire right lower extremity. b. Essentially normal over left lower extremity.

*Course in Hospital.* Treatment consisted of bed rest and penicillin medication. The ulcer on the toe healed very slowly.

*Procedure.* Translumbar aortic angiography was performed on September 11, 1953. The aortogram (Fig. 7) showed complete occlusion of the right common iliac artery at the level of the aortic bifurcation.

*Comment.* On the patient's first admission, with the complaint of minor pain in the first toe, it was thought that his condition presented a good prognosis. If the aortogram had been performed earlier, the complete block would have been found; and a poor result could have been anticipated at a much earlier date.

The patient had a repeat aortogram using 50 cc. of Urokon, and the right iliac artery was visualized about 3 inches below the block at the bifurcation. On January 26, 1954, this segmental block was resected and a cadaver blood vessel graft inserted with very successful results.

## SUMMARY

Experiences with these and other patients have shown that translumbar aortography is of definite aid in cases of abdominal aneurysms. While it was used to determine whether the aneurysm was limited enough in extent to be wrapped, the same information gained is of even more value when the more modern treatment of aortic grafts is to be employed. Surgical exploration is the only alternative at present.

The extent of the obliterated arteriosclerotic process in large vessels is more surely demonstrated by aortography than by other methods, such as palpation and oscillometry. Occasionally the extent of collateral circulation can be seen. Therefore, prognosis is more surely determined. Where localized obstructions are found, the site for vascular grafts may be defined.

Our experience with arterial emboli is still far too limited to come to any conclusions, but in one instance the site at surgery did not correspond exactly with the block seen on x-ray. Reasons for this discrepancy were discussed; but theoretically and in the hands of others, aortography has been an aid.

Various fields of use for this procedure are still under study. Films of the more peripheral arteries might yield further information about their patency and possibly the extent of collateral circulation. Lately we have been using two injections of the radio-opaque dye with improved visualization of the peripheral arteries. The additional hazard is slight. Thus far we have had no untoward effects. There has been no bleeding. On at least one occasion, dye was deposited outside of the aorta with minimal consequences, consisting only of mild back pain for 12 hours.

## CONCLUSION

1. Translumbar aortography is an additional and valuable diagnostic tool in peripheral vascular disease.
2. Aortography may determine whether surgical correction is possible in peripheral vascular disease.
3. The diagnosis of embolus of the peripheral vessels by aortography deserves further study.
4. Translumbar aortography is a relatively easy and safe procedure.

(J.M.S.) 161 West Wisconsin Avenue.

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## UNIVERSITY OF MINNESOTA TO PRESENT COURSE IN EMERGENCY SURGERY

The University of Minnesota announces a continuation course in Emergency Surgery for General Physicians which will be presented at the Center for Continuation Study April 1 to 3, 1954. The course will stress the emergency management of various types of trauma and of acute abdominal conditions. The faculty for the course will include Dr. J. Garrott Allen, Professor of Surgery, The University of Chicago School of Medicine, who will also deliver the annual Clarence M. Jackson Lecture on the evening of April 1. The program will be presented under the direction of Dr. O. H. Wangensteen, Professor and Chairman, Department of Surgery; and clinical and full-time members of the staff of the University of Minnesota Medical School will complete the faculty.

# Chemotherapy Used in Combination With Irradiation For the Treatment of Cancer

By TRAIAN LEUCUTIA, M. D.
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THE number of chemical compounds tried at one time or another for the treatment of various malignant neoplasms reaches into the thousands. Two large groups of these compounds have received particular attention since they comprise several members which, when used in combination with radiation therapy, have proved to be of definite clinical value. These two groups are the metallic substances and the radiomimetic agents. There are also the important groups of the hormones and of the rather controversial biochemical agents, as for example the Coley toxins, the antireticular cytotoxic serum (ACS) of Bogomolets, and the reticuloendothelial immune serum (REIS) of Goldblatt and others. These latter two groups, however, are beyond the scope of the present paper.

### Metallic Chemotherapy

The first attempts to use metallic substances for the treatment of cancer extend back more than 50 years. Gold, copper, silver, bismuth, lead, antimony, arsenic, selenium, and a series of other elements, or their compounds, have been tried. A certain initial response was observed when using most of these substances, but the overall results generally proved disappointing.

At the present time the compounds of only two metallic elements find limited application in certain forms of cancer: (a) the colloidal lead orthophosphate used in malignant, mostly secondary neoplasms of bone and (b) neostibosan, an antimony compound occasionally employed in multiple myeloma. Both of these preparations produce primarily a certain inhibition of the growth of the malignant cells, but above all they act by enhancing the effect of subsequent irradiation. Thus, in a sense, they may be considered as radioadjuvant agents.

*(a) Colloidal Lead Orthophosphate.* At Harper Hospital in Detroit[1] colloidal lead orthophosphate, in association with deep roentgen therapy, has been used as a routine method for 25 years. During this period of time 658 cases were treated, the great majority of these consisting of osseous metastases from primary carcinoma of the breast, prostate, thyroid, or other organs and more rarely of primary malignant neoplasms of the bone.

The rationale of the procedure is based on the fact that there is a definite affinity of the lead for the osseous system, as is well demonstrated by the pathognomonic roentgen appearance observed in chronic plumbism. Chemical analysis and diffraction studies have shown that the intravenously injected colloidal lead orthophosphate, after the initial retention in the spleen and liver and to a lesser extent in the lungs, gradually migrates to the skeleton, where it takes part in the metabolism, replacing for a limited time normal calcium and possibly magnesium in the solid structure of the bone.

By taking into consideration these observations one may assume that the injection of colloidal lead orthophosphate several days prior to the administration of the conventional roentgen therapy enhances the efficacy of the latter, especially when there is a diffuse involvement of the osseous system by the malignant neoplastic process. There are three reasons for the assumption of such an enhanced effect: first, the lead has a certain toxic action in itself; secondly, there is a direct destructive action by the roentgen rays; and thirdly, the secondary electrons emitted during roentgen therapy by the heavy lead atoms deposited in the bone add to the primary ionization produced by the irradiation.

The dose of colloidal lead orthophosphate* is 1.5 mg. per kg. of body weight, injected intravenously within three to five minutes. Three to four days later the roentgen therapy series is started and carried out with the conventional technic. The entire procedure is repeated in about two months and

* Prepared by Crookes Laboratories, Inc., New York, N. Y.

may be resumed at shorter or longer intervals thereafter depending upon the subsequent course of the disease.

Symptomatic improvement is observed in about one month after the completion of the first series of treatments, and in the early cases a solid reossification of the bone is obtained in about three to four months. Although no cure is possible except in a few of the primary bone tumors, complete functional rehabilitation is often accomplished for years. Even in the more advanced cases greater palliation is secured than when using roentgen therapy alone.

*(b) Antimony Compounds.* Rubinstein[2] more recently reported favorably on the effect of antimony compounds, especially neostibosan, in patients with multiple myeloma. The best results were obtained when the administration of this drug was followed by deep roentgen therapy. Serial bone marrow studies revealed that the antimony produces cytologic changes indicative of increased radiosensitivity, thus rendering the myeloma tissue more responsive to subsequent irradiation. Although no definite conclusions can be drawn as yet as to the final therapeutic value of the antimony, it appears that its action is not unlike that of the lead when used in combination with roentgen therapy.

Perhaps it should also be mentioned here that at the present time numerous metallic and nonmetallic elements and their compounds are being introduced for the treatment of cancer in various radioactive forms, as for example radiogold ($Au^{198}$), radiocobalt ($Co^{60}$), radiophosphorus ($P^{32}$), radioiodine ($I^{131}$), radiosodium ($Na^{24}$), radiostrontium ($Sr^{90}$), etc. This has opened up an entirely new field of exploration, and there is every reason to believe that several of these therapeutic agents will soon occupy important places among the already accepted methods of our cancer treatment armamentarium.

### Radiomimetic Chemotherapy

The name "radiomimetic" is used to express the fact that the chemical substances included in this group produce cellular alterations which show a close parallelism to the well-known biologic effects of the roentgen rays. Although the fundamental mode of injury has not been accurately determined in either case, it has been demonstrated experimentally that under certain conditions the actions of most members of this chemical group and of the roentgen rays or other forms of irradiation are at least additive. The end result is complete dissolution of the cells if the quantities administered are large, or varying degrees of growth inhibition if the doses are smaller.

Based on such considerations a rather impressive number of radiomimetic compounds have been tried recently, mostly in combination with conventional roentgen therapy. The most important among them are (a) the mustards; (b) urethane; (c) the aromatic diamidines, such as stilbamidine and pentamidine; (d) the antagonists of the folic acid, including aminopterin, teropterin, amethopterine, and amino-an-fol; and (e) the ethylenimine derivatives, including TEM (triethylenemelamine), DEPA (diethylenephosphoramide) and TEPA (triethylenephosphoramide).

Space does not permit entering into a full discussion of the relative value of all of these new preparations. It may be stated briefly, however, that with the exception of the mustards, nearly all of them have proved to be of limited usefulness. Although temporary palliation, especially in the advanced cases, is not infrequently obtained, there is no indication that any of the enumerated radiomimetic agents is able to cure a single type of the many varieties of malignant lesions treated. At the present, urethane[3-6] is being advocated in multiple myeloma and the chronic leukemias; and the aromatic diamidines[7] are used in multiple myeloma for the relief of pain. The folic acid antagonists[8,9] differ from the other radiomimetic agents in that they have a beneficial influence not only on the chronic and subacute forms of the leukemias but also on about one-third of the acute leukemias as well, the amelioration occasionally lasting as long as one year. The ethylenimine derivatives[10,11] are still under study but it already appears that they, too, will find only limited applicability, mostly in the group of leukemias and in Hodgkin's disease.

By far the most experience so far has been gained with the mustards,[12-14] which have been used longer and more widely than any of the other radiomimetic agents. The first attempts were made shortly after World War II and, considering the almost infinite

TABLE 1—HODGKIN'S DISEASE

| Year | Cases | DRT Alone | % Survival | | Treatment DRT+NMT | % Survival | |
|---|---|---|---|---|---|---|---|
| | | | 3 Yr. | 5 Yr. | | 3 Yr. | 5 Yr. |
| 1947 | 28 | 14 | 36 (5) | 21 (3) | 14 | 50 (7) | 35 (5) |
| 1948 | 15 | 6 | 33 (2) | ---------- | 9 | 55 (5) | ---------- |
| 1949 | 21 | 3 | 33 (1) | ---------- | 18 | 50 (9) | ---------- |
| Total | 64 | 23 | 34 | 21 | 41 | 51 | 35 |

DRT = Deep roentgen therapy.
NMT = Nitrogen mustard therapy.

variety of the mustards which can be prepared, a voluminous amount of literature soon grew on the subject. The most commonly used compound at present is the nitrogen mustard $HN_2$ [methyl-bis (B-chloroethyl) amine hydrochloride], although certain aromatic nitrogen mustards and sulphide mustards are also employed. The $HN_2$, which is freshly prepared in a solution of 1 mg. per cc. strength, is given in doses of 0.1 mg. per kg. of body weight, injected daily for 4 days into the rubber tube of a saline intravenous system already in operation, to avoid local thrombosis. The roentgen irradiation is carried out concomitantly and is usually extended beyond the series of injections. The entire course of treatment is repeated within 8 to 10 weeks and, if necessary, at the required intervals thereafter. A perusal of the published material reveals that the addition of mustard therapy to conventional roentgen therapy helps in improving the results in Hodgkin's disease and in oat-cell carcinoma of the lung but is ineffective in other forms of malignant neoplasms.

At Harper Hospital in Detroit nitrogen mustard therapy has been used in association with deep roentgen therapy since 1947. In the group with Hodgkin's disease, half of the cases first were treated by a combination of the two agents and the other half by roentgen therapy alone, for comparison; then gradually the combination was adopted for all cases as a routine measure.

As shown in Table 1, the 3-year survival rate increased from 34 to 51 per cent when combining nitrogen mustard therapy with deep roentgen therapy, and the 5-year survival rate increased from 21 to 35 per cent. A definite increase in the survival rate was also observed in the cases of oat-cell carcinoma of the lung.

## Conclusions

Repeated attempts to use metallic substances with or without association of radiation therapy for the treatment of cancer remain to date generally unsuccessful. At the present the compounds of only two elements find limited clinical application: (a) colloidal lead orthophosphate, used mostly in secondary and in a few primary malignant neoplasms of the bone, and (b) neostibosan, an antimony compound, occasionally employed in multiple myeloma. Both of these preparations act as radioadjuvants so that the best effect is secured when their administration is followed by roentgen therapy. Although no cure is obtained except in a few of the primary bone tumors, the palliation produced often is very marked and of a relatively long duration.

The most commonly used radiomimetic agents include urethane, the aromatic diamidines, the folic acid antagonists, the ethylenimine derivatives, and especially the several varieties of mustards. With the exception of the latter, nearly all of them are useful only in relieving symptoms. The intravenous injection of the $HN_2$ mustard, combined with deep roentgen therapy, produces a definite increase in the 5-year survival rate in Hodgkin's disease and is also of value in oat-cell carcinoma of the lung.

10 Peterboro at Woodward.

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## BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1954 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referral be made by the family physician; but when this is not feasible, arrangements may be made by writing to the Bureau. Forms for the purpose of referral may be obtained from the Bureau of Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify for which clinic forms are wanted.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of the fact.

| | |
|---|---|
| Kenosha | March 3, 4 |
| Racine | March 10, 11 |
| Green Bay | March 18, 19 |
| Eau Claire | March 25, 26 |
| Wausau | March 31, April 1 |
| La Crosse | April 6, 7, 8, 9 |
| Sheboygan | April 13, 14 |
| Superior | April 28, 29 |
| Appleton | May 6, 7 |
| Fond du Lac | May 12, 13 |
| Chippewa Falls | May 20, 21 |
| Rhinelander | June 2, 3 |
| Lancaster | June 10 |
| Darlington | June 11 |

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

# Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

## REPORT OF A CASE*

CASE 213601—H.C.L., a 53-year-old white male farmer, was admitted to Madison General Hospital on May 9, 1953, directly from an outside hospital. His health had been reasonably good until April 1, at which time chills, fever, generalized aches, and fatigue developed. His family physician was consulted, a tentative diagnosis of "flu" was made, and some "blue and white virus capsules" were prescribed. Resultant vomiting occurred so the use of these tablets was discontinued after 2 days. Because of persistent weakness, the patient remained in bed for an additional 8 days. Soon after this, bilateral testicular swelling and tenderness appeared. It persisted for 5 days, followed by bilateral neck swelling, which likewise subsided spontaneously. The patient's self-diagnosis was "mumps that went down on me." After about 2 more weeks the patient once more tried to return to work only to succumb to chills, fever, and night sweats. He was hospitalized and was treated for approximately 2 weeks with terramycin without improvement. He had become severely constipated during the past 4 days and was not relieved by castor oil. For 10 days prior to admission there had been a productive cough containing approximately 10 cc. of mucopurulent material per day.

Family history and social history were noncontributory.

A physical examination showed a temperature of 106 F., pulse 96, respirations 16, blood pressure 90/60. The patient was acutely ill and toxic. There were no petechial hemorrhages of the skin or mucous membranes or splinter hemorrhages noted. Funduscopic examination showed mild sclerotic changes only, with pigmentary areas about the nasal side of each disk. There was no nuchal rigidity. There was no adenopathy and no sternal tenderness. The lungs were clear. The heart was not enlarged to percussion. The aortic second sound was greater than the pulmonic second sound. The second heart tones were reduplicated over the base. No definite murmurs were audible. There was definite jar tenderness over the liver which was palpable approximately 6 cm. below the right costal margin. The abdomen was distended, and there was diffuse rebound tenderness without localization. The spleen was likewise palpable 4 cm. below the left costal margin, was firm, and descended with inspiration. The extremities were normal, with good peripheral pulsations. Reflexes were equal bilaterally.

*From Madison General Hospital.

### Laboratory Data

*Admission:*

Red blood cell count, 3,530,000; white blood cell count, 2,550; 63 polys, 29 lymphocytes, 8 monocytes; hemoglobin, 67 per cent

Platelet Count: 94,000

Reticulocyte Count: 1.9 per cent

Lee–White Coagulation Time: 10 minutes

Bleeding Time: 30 seconds

Urine: 2 plus albumin, 3–6 white blood cells per high power field, many red blood cells per high power field, epithelial cells

Nonprotein nitrogen, 43.5 mg. per cent; blood sugar, 104 mg. per cent; total protein, 6 Gm. per cent; albumin, 3 Gm. per cent; globulin, 3 Gm. per cent, chloride, 517

*Day Before Surgery:*

Red blood cell count, 2,750,000; white blood cell count, 2,200; 55 polys, 21 lymphocytes, 5 eosinophils, 1 basophil, 15 bands, 2 metamyelocytes; hemoglobin, 9 Gm., or 59 per cent

Nonprotein nitrogen, 58 mg. per cent; total protein, 8 Gm. per cent; albumin, 3 Gm. per cent; globulin, 5 Gm. per cent

*Day After Surgery:*

Red blood cell count, 3,320,000; hemoglobin, 75 per cent; white blood cell count, 6,950; 69 polys, 22 lymphocytes, 2 monocytes, 1 eosinophil, 9 bands

Platelet Count: 137,000

Reticulocyte Count: 8 per cent

Hematocrit: 29.5 per cent

Nonprotein nitrogen: 48 mg. per cent

*Discharge:*

Red blood cell count, 3,980,000; hemoglobin, 12.5 Gm., or 81 per cent; white blood cell count, 4,900; 62 polys, 36 lymphocytes, 1 monocyte, 1 eosinophil.

Platelet Count: 160,000

*Additional Laboratory Tests:*

Immediate direct bilirubin—7.4; indirect bilirubin—6.0

Agglutination Studies: All negative

Blood Culture: Positive 4 days after admission; negative 2 weeks later.

Kepler's Test: Maximum night specimen, 800 cc. and maximum day specimen, 145 cc.

Thorn Test: Eosinophils, 8:00 a.m., 331 per cu. mm.; 12:00 noon, 721 per cu. mm.; 4:00 p.m., 281 per cu. mm. Increase, 118 per cent.

Sputum: Negative for acid-fast organisms.

Electrocardiogram: Sinus tachycardia rate, 130. No evidence of previous infarction.

### X-Ray

KUB and intravenous pyelogram: Some displacement and probable rotation of the left kidney were shown. There was no medium excreted on either side or in the bladder at the end of 18 minutes. A definite mass was visible in the left upper quadrant.

Chest: The heart was normal in size and shape with some increase in truncal markings and calcified hilar nodes bilaterally.

Retrograde pyelogram: The ureter on the left was shown to be somewhat tortuous.

Barium enema: A left upper quadrant mass which exerted extrinsic pressure on the colon was displayed. Small diverticulae were noted in the descending portion of the colon.

### Progress in Hospital

The patient's condition remained grave, and several days after admission he became confused and stuporous. The systolic blood pressure remained within the range of 85 to 100, and the diastolic within the range of 40 to 65. There was increased resistance and tenderness in the left flank and, despite negative suction, the diffuse abdominal distention and tenderness persisted. On May 15, 1953, progressive tachycardia to 150 per minute plus gallop rhythm and a pericardial friction rub occurred, along with evidence of decompensation. A progress chest x-ray demonstrated increased cardiac size with suggestion of left ventricular dilatation and pulmonary congestion. Scout films of the abdomen showed the mass in the left upper quadrant to have increased somewhat in size, with normal psoas muscle shadows bilaterally. Definite icterus, which reached a height of 42 units, was noted on May 19. By May 25 the patient's condition was critical, with multiple ecchymotic areas and petechial hemorrhages appearing throughout the trunk and extremities. On May 29 a diffuse dermatitis appeared over the entire body; it gradually subsided in approximately 1 week. Throughout the patient's hospital course 17 blood transfusions of 1 pint each were administered. An operation was performed on June 25, and the patient was discharged from the hospital in a wheelchair on July 28.

### Discussion

**Dr. F. L. Hummer:** This is the case of a healthy middle-aged man with a febrile illness of 8 days' duration, followed shortly thereafter by testicular and bilateral cervical swelling. This phase was not severe enough to require medical attention and is not described in sufficient detail to allow for diagnosis, though infectious mononucleosis should be considered; and it is possible that the subsequent septicemia had its inception here. At any rate, recovery seemed to occur and the patient returned to work, only to relapse after a short time with a new group of symptoms—chills, fever, and severe back pain. He was hospitalized and given an antibiotic, and attention was directed to the genitourinary tract.

The patient was apparently advised to transfer to Madison General Hospital, where he was found to be acutely ill and severely constipated and to have a productive cough, a mildly elevated temperature and pulse, and a definitely low blood pressure. Apparently no pathology of consequence was found above the diaphragm; but the abdomen was distended, muscle splinting and rebound tenderness were present, and the liver and spleen were very definitely enlarged. The remainder of the physical examination was not remarkable.

The laboratory findings were quite remarkable; in spite of an acute febrile illness, a marked depression of the white blood cell count and platelets, with a milder depression of the red blood cell count and hemoglobin, and a relatively normal differential white

blood cell count were found. The urine showed albumin and red blood cells and white blood cells in greater amounts than could be expected in the usual febrile illness, the nonprotein nitrogen was elevated, and the chlorides were depressed. The direct and indirect bilirubin levels were markedly increased, and the blood cultures were positive shortly after admission. An intravenous pyelogram showed no dye excreted from either side and a mass in the left upper quadrant. Barium enema confirmed the presence of a mass exerting pressure on the colon.

The picture at the moment is that of a very toxic, febrile, jaundiced man, with a paralytic ileus, an enlarged liver and spleen, a mass in the left upper quadrant which is probably distinct from the spleen, red blood cells and white blood cells in his urine, and no dye excreted on intravenous pyelogram, with a pancytopenia and a positive blood culture. My interpretation of this would be as follows: left pyelonephritis developed, followed by septicemia, paralytic ileus, hepatitis, and jaundice. The pancytopenia may have some relation to the "blue and white virus capsules" originally prescribed (if they were chloramphenicol), to an overwhelming toxemia, or to hypersplenism.

The course of the illness was critical and protracted and several complications occurred; on May 15 signs of pericarditis and possibly pulmonary embolism appeared. The former subsided from a friction rub to a click after 4 days, and the pulmonary signs disappeared. Tachycardia was present but there were no signs of myocardial infarction. The patient became disoriented, his jaundice deepened, ecchymotic areas and petechial hemorrhages appeared, and he lapsed into coma. The abdomen was still tender and distended, and the mass in the left upper quadrant was increasing in size. After a critical 6 weeks, improvement began and surgery was performed. Surgery probably included a splenectomy since there was a tremendous change in the white blood cell count and platelets within 24 hours.

When the patient was admitted, the blood picture resembled that of hypersplenism, in that all formed elements were depressed. In severe toxemia, anemia is common and in many diseases leukopenia occurs, but the thrombocytopenia in addition makes a splenic factor likely. Splenomegaly and leukopenia occur in several diseases—typhoid, malaria, primary tuberculosis of the spleen, syphilis, Banti's syndrome, and the aleukemic phases of leukemias; but thrombocytopenia is rarely present and never do the white blood cells and platelets change so radically following surgery in these conditions. Such a change is characteristic of thrombocytopenic purpura and hypersplenism, however. Thrombocytopenic purpura has been observed in hyperthyroidism, infectious hepatitis, pregnancy, and following burns and extensive radiation. In this case, the depressed white blood cell count and the normal bleeding and coagulation times serve to exclude true thrombocytopenic purpura.

Following surgery the patient improved but his skin became darker, definitely olive in color, and desquamation occurred. This finding, plus the consistently low blood pressure, raises the question of Addison's disease. While there is insufficient evidence given to make this diagnosis, we can be suspicious of adrenal insufficiency, as the background for such is present. An abscess involving the left kidney and adrenal could have destroyed this gland, and the marked toxemia and septicemia could have produced hemorrhagic degeneration of the right adrenal, with resultant insufficiency.

In summary, then, I postulate the following train of events: this man had an original febrile illness of unknown etiology which initiated left pyelonephritis, the latter in turn being the source of the septicemia. From this point toxic hepatitis and paralytic ileus developed and toxic splenitis with functional hypersplenism occurred. During his illness, pericarditis and possibly pulmonary embolism occurred, azotemia was present, and adrenal insufficiency developed. The most remarkable thing in a most unusual case was recovery of the patient.

Though hypersplenism is usually associated with an afebrile state and a much milder course than in the present instance, a recent report has mentioned this complication in several instances associated with an acute infectious process.

### Gross and Microscopic Pathology

**Dr. P. G. Piper:** The spleen weighed 1,150 Gm. The surface was involved by a perisplenitis. On cut section the pulp was deep red in color and firm to palpation. The Malpighian corpuscles were readily identified. Microscopic examination of the spleen revealed moderate distortion of the parenchymal

architecture with engorgement of the sinuses. No micro abscesses were found within the splenic pulp.

Fig. 1—Cut surface of the kidney showing the marked necrotic changes within the medullary portion and the poor gross differentiation between the cortex and medulla.

The left kidney weighed 250 Gm. The capsule stripped with moderate difficulty, presenting a coarse nodular surface. Small macroscopic areas of abscess formation were found scattered over the surface of the cortex. On cut section they extended down through the cortex into the acutely involved medullary portion of the kidney. The medullary portion and associated calyces appeared necrotic and deep yellow in color in contrast to the pale ischemic renal parenchyma surrounding them. The pelvis was unremarkable. There were several large areas of abscess formation which extended from the raised surface above the cortex of the kidney down into the kidney parenchyma proper. Microscopic examination of multiple sections taken from this kidney revealed micro, as well as the confirmed macroscopic abscess formations. In the areas of abscess formation no organisms were identified. Acute and chronic inflammatory cells were found in a wedge-shaped configuration extending from beneath the capsule down into the renal pyramid. The glomeruli were relatively free of any microscopic alteration. The renal vessels were unremarkable. There was some hydropic change of the tubular elements, but the significant microscopic as well as gross finding was that of acute pyelonephritis with multiple macro and micro abscess formations.

Biopsy of the skin taken from an area of pigmentation revealed a triangular segment of icteric skin on gross examination. There was a normal underlying fatty subcutaneous tissue. On microscopic examination there was increased pigmentation of the overlying skin surface, and occasionally a flattened rete peg with some thinning of the epidermis was found. There was a moderate to minimal increase of melanin pigment in both the epidermis and corium, and this pigment was found chiefly above the nucleus of the basal cells. Occasionally it could be found in the lower layers of the rete Malpighii. There was no inflammatory reaction in the corium.

The above microscopic changes are compatible with a diagnosis of Addison's disease, but such a diagnosis cannot be made from microscopic sections because of the similar histologic picture found in a nonspecific hyperpigmentation of the skin and in the normal skin of the Negro.

Cultures taken from the splenic pulp, kidney, urine, and blood all revealed the presence of pure strain of Pseudomonas aeruginosa; and a classic green discoloration to the culture media, both fluid and solid, was found associated with the growth of this organism.

### Questions and Answers*

**Q.** Was a bone marrow study made? **A.** A sternal marrow aspiration performed the first week of hospitalization was unsatisfactory because of dilution with peripheral blood. A rib biopsy was contemplated at the time of surgery but was omitted.

**Q.** What do you feel is the nature of this patient's jaundice? **A.** From the evidence at hand it would seem most likely to be a hemolytic jaundice. The reticulocyte count recorded is 1.9 per cent, 3 days after admission; however, the failure of the blood count to rise after repeated transfusions would point toward a hemolytic process. Fecal urobilinogen studies would give us the answer, but the patient was too ill during this period to adequately carry out this test. Theoretically one could call this a toxic hepatitis in view of the progressive abnormalities shown by the liver function tests and the generalized sepsis.

*Questions asked by audience and answered by **Dr. A. J. Richtsmeier.**

**Q.** What antibiotic was employed and for what length of time? **A.** Polymyxin B sulfate was first administered on May 21 after the blood cultures showed a Pseudomonas type organism and was continued in the dosage of 50 mg. every 8 hours. Because of the elevation of the nonprotein nitrogen to over 100 mg. per cent, it was with considerable fear and trepidation that we continued the administration of this antibiotic; however, our hands were tied because of the culture and sensitivity studies. The dosage was decreased shortly before surgery, then once again administered at full dosage the week after the patient's surgery. He was maintained on this dosage until approximately 1 week prior to discharge.

**Q.** I thought polymyxin was nephrotoxic and contraindicated in severe renal failure such as demonstrated here. **A.** Previous reports have inclined to exaggerate the nephrotoxicity of polymyxin. I received word from Doctor Jawetz and Dr. Donald Searle of Burroughs Wellcome Laboratory who share these views and are interested in this patient's favorable results and renal compensation while on polymyxin B sulfate.

**Q.** I take it from the report on the Kepler's and Thorn tests that this patient was definitely Addisonian. Was any substitution therapy given? **A.** This patient was definitely Addisonian clinically. In the laboratory the Thorn Test was not satisfactory because of the increased blood urea. However, failure to show any eosinophil drop was significant. We felt that replacement therapy was mandatory; as a result the patient received 2.5 mg. of desoxycorticosterone acetate in oil every day for 4 days before and 1 week subsequent to surgery. Cortisone was given several days before surgery as well as the morning of surgery. This was slowly reduced in 12.5 mg. amounts, and he was discharged on 25 mg. a day plus added salt.

**Q.** Is the Addison's disease permanent or transitory? **A.** This we feel is transitory in that the patient has been off cortisone for 2 months without any evidence of remission. He has been off added salt for a month also without symptoms, and the pigmentation is no longer present. Doctor Schoenenberger explored the left adrenal at the time of nephrectomy, and the infection had spread to this organ and was quite extensive. It is his feeling that the left adrenal was possibly involved by the infection. Evidently this patient had enough return of function on the right to maintain him.

**Q.** Is there any evidence that chloromycetin was given this patient? **A.** We checked with his family doctor by telephone and found that no chloromycetin had been given.

**Q.** I am not sure as to the chain of events in this patient. Is the infection the result of the leukopenia? **A.** Our initial thoughts were along the lines of an aleukemic leukemia or malignant lymphoma with terminal bone marrow suppression and pancytopenia. In questioning this patient's wife, we found that the patient had what he called "lumbago" in November of 1952 and February of 1953. These were probably recurrent attacks of pyelonephritis. Because the Pseudomonas organism was obtained in pure culture from the removed left kidney, we feel that this was the port of entry and that the pancytopenia was produced by the overwhelming sepsis. In May 1952, Lollinger *et al.* published a paper in which they reviewed cases of hypersplenism in Ohio State. There were 54 patients with secondary hypersplenism. Seven of these cases were due to infection and only a very small percentage showed panhematocytopenia. The Pseudomonas organism, which is usually a non-pathogen existing on the skin, gained entrance to the blood stream through the repeated attacks of pyelonephritis and, because of the overwhelming septicemia, produced a secondary hypersplenism. The Addison's disease, I feel, is probably due to direct adrenocortical destruction from the kidney or blood stream infection. Certainly there is much evidence for the latter in view of the involvement of the pericardium, liver, gastrointestinal tract, and other organs.

**Q.** What is the present status of this patient? **A.** He has gained over 45 pounds since his discharge; and when last examined on October 12, he had been off cortisone and supplementary salt for 1 month without difficulty. We would like to retest his adrenal function but unfortunately cannot get him anywhere near a hospital for these studies.

### Summary

**Dr. A. P. Schoenenberger:** This patient was seen in consultation out of town on the day of the hospital admission. On examination of the patient the temperature was found to be 102 F. He was acutely ill and toxic and com-

plained of pain in the left flank and abdomen. On physical examination, definite and severe left renal area tenderness was found. Urinalysis showed gross pyuria. A KUB and retrograde pyelogram done 1 week prior to this consultation showed in the KUB a spherical mass over the left kidney but distinctly separated from the kidney. The intravenous pyelogram showed excellent excretory function by both kidneys. On the left there was a definite pyelonephrosis and a marked tortuosity of the upper ureter. Because of the toxicity of the patient, it was advised that he be admitted to Madison General Hospital for further treatment.

On admission the patient was empirically put on penicillin and streptomycin, but in spite of this the temperature rose from 102 F. to 103 F. An intravenous pyelogram done at Madison General Hospital 1 day after admission showed no excretory function by both kidneys, as noted in the protocol. This undoubtedly was due to the azotemia which had developed since the previous pyelogram. A retrograde pyelogram was done under local anesthesia 2 days after admission. A catheter could be advanced to the upper third of the ureter, and 42 cc. of gross pus were aspirated. However, in spite of an ardent trial, the catheter could not be advanced into the renal pelvis because of the marked tortuosity of the upper ureter. The catheter was left indwelling. It was evident from this examination that we were dealing with a hydropyonephrosis on the left which may have been a sequel to a previous infection of the left kidney. The ideal approach to a problem like this would have been exploration and either drainage of the kidney or nephrectomy. However, by this time the blood count revealed a white blood cell count originally of 3,000 and on the second day of only 2,000. Studies were directed toward establishing the etiology of this leukopenia in the interval of which several days elapsed.

At this time the patient had, as Doctor Hummer postulated in the discussion, a paralytic ileus and probably a diffuse peritonitis. The culture of the left kidney urine was reported as Pseudomonas almost simultaneously when the report was made of a positive blood culture due to Pseudomonas. Proper therapy was then instituted, but several days elapsed before the temperature dropped to 100 F. Due to profound prostration, surgery was out of the question. The patient was treated conservatively with continuous administration of polymyxin B. Electrolytes were successfully balanced in the course of several weeks of parenteral treatment.

On June 16 Wangensteen's suction was discontinued. The abdomen became soft, and the patient had a slight desire to eat. However, the hematological findings persisted as on admission. The azotemia, which had risen to 100 mg. per cent nonprotein nitrogen, probably extra-renal due to severe blood destruction, had returned to 38 mg. per cent.

On June 24 the patient was taken to surgery, and a left flank incision was made in an attempt to do a nephrectomy. A severe perinephritis, which had partially organized, was encountered; and the kidney, which was markedly enlarged, was finally freed by sharp dissection. It was uneventfully removed. Upon removal of the kidney the left adrenal was explored, and the tissue appeared hyperemic and red in appearance. There was, however, no demonstrable abscess in the adrenal. The mass previously seen above the kidney was then palpated intra-abdominally. The peritoneum was opened, and the mass presented itself as a splenomegaly. The spleen was removed without difficulty. Although this was a severe surgical procedure, the entire operation was accomplished in 1 hour and 20 minutes.

Perhaps the most spectacular finding following surgery was the patient's general well-being and a white blood cell count rise to 6,500 within 24 hours.

Pseudomonas infections of the urinary tract are reported. However, I have never heard of a hydropyonephrosis due to Pseudomonas with generalized septicemia recovering, either in my personal experience or in the literature.

# Psychologic Needs of the Medically and Surgically Ill Patient*

By DAVID A. BOYD, M. D.**
Rochester, Minnesota

*"'Tis not the body but the man is ill"*
—Dr. Weir Mitchell

PHYSICIANS are prone to rather nostalgic discussions about the "art of the practice of medicine." As with all generalities, this phrase means different things to different people. To some it has meant an intuitive capacity to diagnose a puzzling condition or at least to feel a nagging suspicion which motivates a novel diagnostic or therapeutic procedure. This aspect of the art of medicine can be improved by experience, by habits of logical thought, and by the employment of progressively better diagnostic tools.

It is with another aspect of the art of medicine that we are presently interested, namely the ability of the physician to understand and to deal with the emotional problems of his acutely and chronically ill patients. In previous times this represented a relatively unconscious capacity of the physician to appreciate the feelings and subsequent reactions of the patient and relatives and, in the highly gifted practitioner, the capacity to anticipate these even before the patient and relatives were consciously aware of their developing attitudes. Thus, it was possible to scotch many undesirable emotional and behavior trends in nascent phase while others were contained and ameliorated before they became so deeply entrenched that they constituted a serious barrier to favorable progress. This part of the art of medicine implied that the physician possessed psychologic insights and understanding of reaction potentialities and was able to use these effectively in patient management. It should not mean what has come to be known as a smooth "bedside manner," signifying a sort of cooing ingratiation based on constant conciliation. Even this objection is not based on esthetic considerations but on the fact that a single and exclusive technic is bound to fail because of its lack of flexibility and adaptability to new and varying situations.

To learn these technics of management of the emotional aspects of patients has been difficult in the past because there have been no rules to follow. The practice of this art depended upon the natural gifts of the physician, which consisted of a feeling type of understanding, a sensitivity with which to grasp the total emotional situation, a realization of the paramount practical importance of these factors in patient management, and a sincere motivation to deal with these emotional problems. Finally, he had to be secure enough in his own personality organization to be able to participate in the emotional give-and-take which always occurs in such situations. Previously, such arts and skills have been gained only by years of assiduous trial-and-error technic or by being fortunate enough to have a sensitive and intuitive gift for such relationships. The neophyte in medical practice listened enviously to discussions of "the art of medicine as it used to be in the old days" and wondered how to gain and utilize these artistic skills. Usually he resigned himself to a long preceptorship with a master or the equally painful method of doing the best he could on a common-sense basis.

It has been the contention of psychiatrists that human behavior is not unpredictable and not without established and known patterns. Instead, there are recognized gross types of personality organization and these, when faced with certain stresses and strains, will react in reasonably predictable ways. Once these basic reaction patterns and some of the variations due to special circumstances are understood, it becomes possible for even the medical tyro to use these insights for the comfort and benefit of the patient during the stressful period of acute or chronic illness. Psychiatrists are now interested in the clarification of the basic principles and their reduction to simpler technics which may be utilized routinely by all physicians. Many

* Rogers Memorial Lecture presented at the One Hundred and Twelfth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 6, 1953.

** Sections of Neurology and Psychiatry, Mayo Clinic and Mayo Foundation. The Mayo Foundation is a part of the Graduate School of the University of Minnesota.

challenging ideas and practical suggestions on this topic are presented in a recently published symposium.[1]

### Psychosomatic Interrelationships

It is fundamental in such a discussion that there be a comprehension and acceptance of certain significant psychosomatic interrelationships. There should be no necessity here for an exhaustive dissertation concerning the psychogenesis of some somatic disorders; in fact, so much has already been said of late on this topic that some medical audiences turn a pallid green at the mention of "psychosomatic." But every physician should remember the words of Sir Cyril Burt, "Man is something more than a carcass loosely coupled with a ghost," and should be aware constantly in acute and chronic illness of the continual interplay between these two aspects of the person. Certainly some of the emotional manifestations will be directly stimulated by the organic somatic difficulty. Disturbed emotional states and behavior patterns may be due to protracted pain, metabolic and hormonal upheavals, or other physiologic derangements. Fever and toxic states impart a feeling of unreality or may even disturb the cerebral cortical function sufficiently to short-circuit the customary defensive and inhibiting mechanisms. Strange physical sensations may be misinterpreted and misunderstood, leading to bizarre and frightening notions. These are unavoidable as a part of the disease and should be brought under control by appropriate and effective therapy of the somatic state. However, the large remainder of the untoward reactions are psychogenic in origin. It is essential that these emotional tensions be kept at a minimum because they operate deleteriously in two general ways:

1. By direct aggravation of the specific somatic difficulty through emotional mechanisms which lead to further pathophysiologic disturbances.

2. By preventing the patient from carrying through the therapeutic regimen necessary for his treatment.

As an example we may consider arthritis. There are many who believe that the course of the disease is directly and adversely affected by disturbed emotional states. Certainly, all would agree on the second mechanism, namely, that many arthritics do not carry out the necessary therapeutic regimen because of depression, resentment, or feelings of futility. In many of the chronic disorders these two mechanisms interplay continually in a descending spiral into complete invalidism.

### Concept of Body Image

It becomes apparent immediately that there are significant differences between the emotional problems associated with acute medical and surgical conditions and those associated with conditions of a more chronic nature. Even in each of these categories there are wide variations, depending upon the part of the body involved; the type of involvement; the amount of pain, disfigurement, restrictions or disturbances of body function; esthetic considerations; and a hundred other factors. Therefore, it is possible only to discuss general principles as they relate to the overall problem. However, there is at least one common and basic factor in all illness and this concerns the patient's personal concept of his body image. The concept of body image means the picture of our own body which we form in our mind and the way our body appears to ourselves.[3] Thus, tremendous funds of feeling are invested in this body image as witnessed by the almost innumerable appliances sold to add, subtract, emphasize, de-emphasize, or otherwise modify it in external appearance.

But the concept of body image extends even deeper—into the interior cavities as well—and here may be concerned not with anatomic configuration, but with qualities that may be described by such terms as healthy, strong, clean, and efficient. The preservation of the total body image in the highest state of esthetic beauty and vital functioning is a matter of greatest concern to all, and any illness or surgical procedure which threatens the continued integrity of this body scheme is emotionally devastating. The emotional values invested in the body image by different individuals may vary in amount, some having a compelling need to be strong, healthy, muscular, symmetrical, or beautiful. The threat of illness to the body image is provocative of intense and sometimes disorganizing anxiety, and this may be the focal point in the initiation of various emotional defenses and retreats which are manifested by disturbed behavior. If the patient is already carrying crippling anxieties and conflicts from an earlier period and the illness attacks a highly significant area in his body

image, the effects may be overwhelming emotionally.

Such circumstances were apparent in the instance of a middle-aged business woman whose condition was diagnosed as "brittle diabetes." Her earlier life had made her a most insecure person, always on the brink of an abyss of anxiety and depression. She gained security by driving work which used up her funds of tension and made her sufficiently weary to sleep at night. She grasped greedily for responsibility and authority, striving to make herself essential to others—thus they would always need her. She constantly reviewed her record of business success and progressively greater responsibility to prove her adequacy to herself. In her estimation, her body was a splendid power plant designed to provide her with the physical means of evading anxiety by carrying her into activities. When she saw others who were ill, she speculated uneasily on the wretchedness of not being able to advance the physiologic throttle at will and feel the answering physical surge of vital power. When first told she had diabetes, she collapsed. Her further course was characterized by bouts of illness as she experimentally tried to drive herself as before. When she learned that she could not, she avoided her friends, who would see her as a weakling, discovered that her facial appearance was changing and her skin wrinkling "like a sick person," and abandoned herself alternately to miserable despair or flights of wish-fulfilling fantasy that she really did not have diabetes. The emotional values that she had invested in a healthy and perfectly functioning body image were so tremendous that she became emotionally disorganized when this concept was threatened.

On the other hand, if a patient has reasonably healthy defenses to utilize, the threat to body image may be of much less importance. This was exemplified in the instance of a woman in whom a fore-quarter amputation was necessary and who was postoperatively faced with the problem of living without an arm and shoulder girdle. It was obviously impossible to hide such a defect—clothes would not hang properly and activities must be limited. Yet with all the disturbance of body image she was emotionally stable and poised. The psychiatric history revealed that she had had a happy and harmonious past with a minimum of disturbance in personal relationships. Her marriage was extremely satisfying; and when her husband came into the room, his facial expression left no doubt that he still thought she was lovely—and hers left no doubt that she knew it.

### Disturbances Related to Acute Illness

It is difficult to overemphasize the importance of the preceding concept, and this should be borne in mind throughout the further discussion of the emotional differences between acute and chronic illness. Acute medical and surgical illnesses bring with them all of the terror and disorganization of a sudden and catastrophic calamity. Although the patient may have hope of recovery, he also has the realization that this acute situation may soon eventuate in death or chronic disablement. Each moment, each new sensation, each new worried facial expression may be a step to another dangerous and painful crisis. And of course the illness, like the tax collector, came just at the wrong time. There is no opportunity to get one's business or spiritual affairs in order, serious family and financial problems are pending, and there are memories of past evil omissions and commissions which should be righted if there is yet time. Members of the distraught family, either unable to conceal their anxiety or desiring to free themselves of it by giving it to someone else, communicate their uncertainty to the patient to add to his already adequate supply. Finally, there is the fear of death, with all its mystery and finality. It is difficult to find out much about the fear of death because practically all discussions with healthy friends indicate that they do not have it and cannot see why anyone else should. Nevertheless, this fear is widespread and potent, and acute illness may evoke it in intense and overwhelming amounts.

### Disturbances Related to Chronic Illness

Conversely, chronic illness or repeated corrective surgical procedures provide ample opportunity for speculation, rumination, and compulsive reviewing of the problem. Chronic illness and the consequent changes in the patient's life and opinion of himself pose a problem unique to each individual. The establishment of a chronic illness is not a matter of either medical addition or surgical subtraction. It is not the old person plus a new disease nor the old person minus a significant member of his body; it is the

*(Continued on page 169)*

# THE MEDICAL FORUM

## SOCIETY GROUP SEEKS TO EXPOSE VITAMIN PEDDLERS

### Wisconsin Attorney Joins AMA Staff in Washington, D. C.

Washington, Feb. 8.—Frank W. Kuehl, former Madison attorney, has been named legal advisor for the Washington office of the American Medical Association. He joined the staff on Feb. 8.

Kuehl, a native of the Fountain City area, has been bond counsel for the Reconstruction Finance Corporation since 1933.

Prior to that, he was legislative assistant to Governor Blaine in 1923 and 1925. He became assistant attorney general of Wisconsin in 1927, a post he held for 6 years. He was bank stabilization director for Wisconsin during the early 30's. Active in many political campaigns, he was delegate to the Republican National Convention in 1924 and 1928.

FRANK W. KUEHL

Kuehl is a graduate of the University of Wisconsin. His wife, Jane, is the daughter of the late Dr. O. M. Sattre of Rice Lake.

### *SCHOOL HEALTH CONFERENCES SLATED FOR EAU CLAIRE, OSHKOSH IN SPRING*

Madison.—The first of a series of school health conferences will be held April 7 at Wisconsin State College in Eau Claire under the sponsorship of the State Medical Society of Wisconsin and the Wisconsin School Health Council.

The second conference will be held in Oshkosh on May 13. Similar meetings will be held at Stevens Point and La Crosse later in the year.

**Cooperation between the home, the school and the health professions for the improvement of child health will be the major theme of the conferences. The Eau Claire conference begins at 9:30 a.m. and concludes following a dinner speaker.**

Dr. E. H. Pawsat, Fond du Lac, chairman of the Division on School Health of the State Medical Society, will serve as the presiding officer at the Eau Claire meeting. Other physicians participating in the general program are Drs. H. Kent Tenney, Madison, President of the State Society; E. S. Gordon, Professor of Medicine at the University of Wisconsin; and W. W. Bauer, Director of Health Education of the American Medical Association.

Part of the day will be utilized for panel discussions to go into details about the most serious school health problems. Dr. Clifford Olson of Baldwin will be moderator for a panel on health examinations of pupils and school personnel, Dr. Herbert Dasler of Amery will participate with several others on the panel.

**A panel on the control of disease will be moderated by Dr. Rex E. Graber, district health officer of Chippewa Falls. Dr. O. G. Moland of Augusta will also serve on this panel.**

Emotional problems of child growth will be discussed by Drs. H. Kent Tenney, A. A. Lorenz of Eau Claire, and E. S. Gordon of Madison.

Dr. Walton Manz of Eau Claire will serve as moderator for a discussion of health aspects of athletics.

All physicians in the areas of the conferences are invited to attend.

Madison, Feb. 13.—A program aimed at alerting physicians and the public to the activities of "unscrupulous peddlers of high priced vitamins, minerals and other dietary supplements" was proposed by the Council on Medical Service of the State Medical Society at its meeting Feb. 13.

Alarmed by the widespread sale of vitamin and mineral preparations at costs far exceeding prices of equivalent products in local drug stores, the Council urged immediate preparation of authoritative material for publication in the Wisconsin Medical Journal and the state press.

**"The aged and chronically ill are the chief targets of house-to-house peddlers which seem to have flooded the state," several Council members reported. "The way some pill salesmen prey on those whose sole support is from relief or old-age assistance is completely unconscionable."**

Physicians are not opposed to the use of vitamin or mineral supplements, providing the individual really needs them to maintain or improve his health, according to the Council. "What the public apparently doesn't realize is that equal or better preparations are available from the local drug store at from one-third to one-quarter the price paid to the itinerant salesman."

Present at the Council meeting were Drs. D. E. Dorchester, Sturgeon Bay, chairman; T. D. Elbe, Thiensville; R. L. MacCornack, Whitehall; C. G. Reznichek, Madison; J. S. Devitt, Milwaukee; and W. J. Fencil, Monroe.

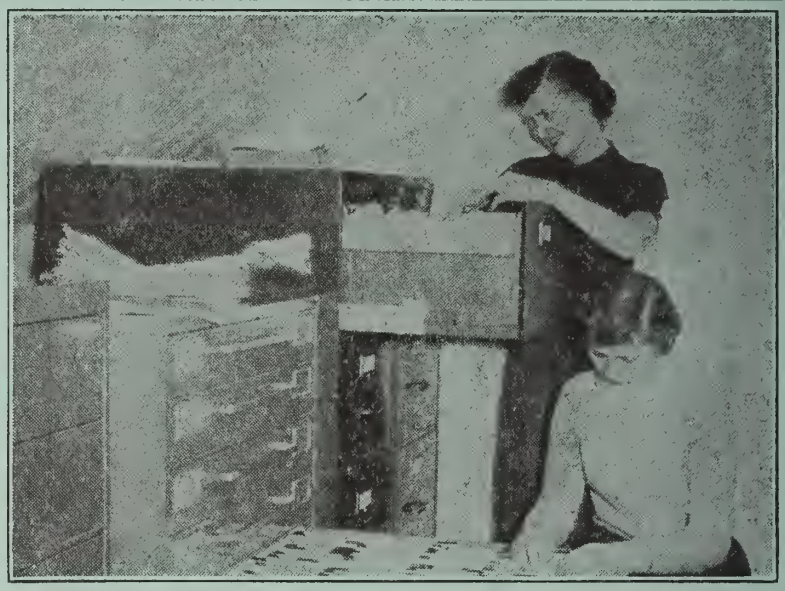
Among other actions of the Council were:

1. Approval of a study of first aid procedures as outlined in the American Red Cross manual to determine if revision may be necessary in light of current medical practices.
2. Approval of a statement of ethical principles to guide physicians and insurance carriers with reference to Work-

*(Continued on page 168)*

# PROCESSING WPS CLAIMS REQUIRES WORK OF 19 PEOPLE

**What are the services performed for its members by the State Medical Society? This is the fifth in a series of articles designed to tell about what goes on in the society's headquarters—and why.**



WPS FILING IS MAJOR JOB

One of the major activities housed by the State Medical Society building in Madison is the claims department of Blue Shield, the physicians' plan of prepaid health insurance.

This department occupies the entire third floor of the building. Through it must pass every claim for services under the plan. To explain the functions of the department, it is necessary to explain what processing is actually involved in the payment of a claim.

There are two general types of claims—those made for the medical or surgical care a patient receives in a hospital, and those made for care given at the patient's home or the physician's office.

**All claims for care given in the hospital come from Blue Cross in the form of a hospital admission notice. The girl who handles the notice checks to be sure that no other claim is being processed for the same individual for the same procedure. Once this has been determined, the claim is given a number of its own, and the doctor's code number is put on. The numbering of claims starts afresh each month with number one.**

### Verify by Teletype

If all necessary information is not included in the admissions report, a member of the department teletypes to the Blue Cross office in Milwaukee for clarification.

The PSR—physician's service report—is then typed in triplicate along with a card which is detached and used as an index card. The triplicate PSR goes to the physician to be filled out, and the admissions notice goes into a pending file to await return of the PSR.

The doctor places his diagnosis and procedure on the PSR, keeps a copy for his own file, and returns the other two to the claims department. There they are attached to the hospital admission and taken to the coding room.

The coding consists of writing on the PSR in the appropriate spaces figures which indicate the following things:

1. **The type of contract, whether individual or group, A or B schedule, etc.**
2. **The relationship of the patient to the subscriber—wife, son, daughter, etc.**
3. **The effective date of the contract.**
4. **The place where service was rendered—home, office or hospital.**
5. **The type of benefit, whether for medical, surgical, anesthesia, x-ray or maternity care.**
6. **The code number of the physician with a symbol to indicate whether or not he is a WPS participating physician.**
7. **The procedure performed by the physician, for which payment is to be made.**

One of the two copies the doctor returned now goes to the accounting department for payment, and the other goes into a permanent case file, while the index card is placed in a permanent index file.

There is no admission sheet to start from in the case of home and office treatment claims. Notification of all such claims comes in via correspondence from patients, bills from physicians, or PSR's filled out directly by the physician.

In the case of either letters from patients or doctor bills, the piece of mail is returned to the sender with a set of blank PSR's and an appropriate form letter, asking that the PSR be filled in by the doctor. When the PSR is returned, a form is sent to Blue Cross requesting verification of coverage—for people still confuse Blue Shield with other plans, or with Blue Cross, with the result that they ask for payment from the wrong source.

### Procedure Same

When the form comes back from Blue Cross with the coverage verified, the index card is typed, the material is coded and the procedure is generally the same as in hospital cases.

**This department includes the claims director, the assistant claims director, their secretaries and the WPS office manager. Two other secretaries handle correspondence and inquiries, and interview people who drop in at the office to inquire about claims.**

There are four employes working full-time on hospital admissions and two on the coding of these cases. Two others work en-

# INVESTIGATORS SEEK END TO CHARITY RACKETS

New York, Jan. 20.—High-powered promoters and racketeers who siphon off millions of dollars from money given for charity have been under fire in Manhattan's county courthouse, according to reports in Time Magazine and Better Business Bureau Bulletins.

A committee of New York state senators and assemblymen listened in stunned silence while a parade of reluctant witnesses unfolded a sordid tale of charity profiteering.

### DAV Floods Mail

**The Disabled American Veterans collected $21,480,000 over a period of three years by means of a series of contests and a campaign which featured mailing out cheap ball-point pens on a "remit or return" basis, it was reported.**

Of this sum, the expenses of the fund-raisers took $14,529,000, "administrative costs" ate up another $2,400,000, and the rest went for lobbying. Not one penny went for the direct aid of a needy veteran, according to reports.

The National Kids Day Foundation, Inc., a west coast organization, was reported to have collected $3,978,000 in five years, of which only $302,000 was spent for charitable purposes.

### Widows Get Mite

A Chicago outfit raised $2,531,000 for the relief of war widows and orphans, of which $309,000 was left after "fund raising expenses" were deducted.

**Worried representatives of such legitimate charities as the Salvation Army, the Red Cross and various Community Chests pointed out their fund-raising costs rarely exceed 12 per cent.**

The committee promised to seek legislation which would end the charity rackets in their state once and for all. It can still go on in many other states, however, as long as it can be proved that some amount goes to a genuine charity.

Wisconsin citizens have some protection from this form of racketeering. There is a statute listed under the fraudulent advertising law which makes it illegal to advertise solicitation of funds for charitable purposes unless a clear statement is made of the percentage of money that is to go to the charity.

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tirely on home and office cases, including the coding of this material, and two work full-time on the files.

Two others have specialized jobs and, apart from this work, help out as needed with the other procedures. One of these handles the teletype, and the other the sorting ond distribution of the mail.

In the average month, between five and six thousand cases are numbered.

## New Medical Schools to Graduate Classes Soon

Chicago, Jan. 6.—There have been several important developments during the past year regarding the establishment of new medical schools and the expansion of schools of the basic medical sciences to full four-year status.

According to the annual report of the AMA Council on Medical Education and Hospitals, the University of Puerto Rico School of Medicine and the University of British Columbia School of Medicine will graduate their first classes in June of this year.

Another new school, the University of California at Los Angeles, will graduate its first class in 1955 while the University of Miami School of Medicine will do so in 1956.

Four-year courses will soon be offered by the University of Mississippi, West Virginia University and the University of Missouri, all of which have two-year courses now.

Other new schools which are still in the planning stage are the Albert Einstein College of Medicine connected with Yeshiva University in New York; a medical school for the University of Florida at Gainesville, and another under auspices of the University of Kentucky at Lexington.

Vermont, Maine and New Hampshire have already passed enabling legislation to permit a New England regional higher education plan which would include a medical school. New Jersey, Massachusetts and Connecticut have been studying the possibility of establishing schools, but have taken no action.

## Wisconsin GP's Sponsor Student Essay Contest

Madison, Feb. 12.—"The General Practice of Medicine as a Career" is the subject of an essay contest for Wisconsin medical students, sponsored by the Wisconsin Academy of General Practice.

The group has announced that senior medical students at the University of Wisconsin and Marquette University are eligible for the contest. A prize of $100 will be awarded for the best essay submitted from each school.

Dr. C. G. Reznichek, Madison, President of the Wisconsin Academy, will present a prize to the U.W. student winner. Deadline for submission of essays is March 15.


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# PROBLEMS OF MD UTILIZATION IN MILITARY DISCUSSED

**In order to acquaint physicians with some of the problems connected with providing medical personnel for the armed forces, the text of a speech given by Brig. Gen. Howard A. Rusk, M. D., chairman of the Health Resources Advisory Committee, is reprinted here. The speech was delivered before a recent meeting of Military surgeons in Washington.**

Washington, Jan. 6.—The Armed Forces now have on active duty some 13,000 physicians. Of these about 4,000 are regular officers and 9,000 are reserve. Most of the reserves were brought to duty directly or indirectly as a result of the doctor-draft law.

This number of physicians provides a ratio of about 3.6 per 1,000 troop strength—a ratio which is markedly lower than the 6.0 or 6.5 which was the order of the day during most of World War II. This marks a tremendous accomplishment in improved utilization, though even greater accomplishments seem achievable.

For a variety of reasons, it has not been possible in the current mobilization period to build up the medical and dental corps of the Armed Forces without special legislation—legislation which, in effect, is discriminatory to physicians and dentists as a class.

### Finger on All Under 50

This legislation has literally put the finger on all men under the age of 50 in these professions. Though reserve officers were exempted from registration under the law, the Department of Defense has been directed by the President of the United States to call up reserves in parallel order with Priority definitions.

Selective Service reports indicate that, so far, the effect of Public Law 779, and its successor, the New Public Law 84, has been as follows:

For physicians, there have been called to active duty or commissioned over 8,000 registrants in Priority I or 70% in that group; over 1,400 registrants Priority II, half of that group; and 2,200 or 6% in Priority III. Over 1,500 of these registrants have already completed service.

Obviously, differences in priority and age distributions have an important relation to the impact of the draft law.

The Secretary of Defense has directed that, within the coming year, the ratio of physicians to troops is to be reduced to 3.2 per 1,000 (including interns and residents.)

Unfortunately, it is not going to be possible to attain this ratio before next fall. The completion of internships and residencies by many young men in Priorities I and II and by those in Priority III with obligations under the regular as well as the special draft who wanted to complete their obligation for military service before entering practice brought a flood of July volunteers. This flash flood was intensified by the peace in Korea.

To further complicate the situation, the Department of Defense, not anticipating so many volunteers, had issued a draft call early in July. In addition, the number of men asking for early release under the provisions of the new draft law was smaller than anticipated. The result of all of this, in spite of the partially successful efforts of the Department of Defense to stem the flood, has been to keep the number of physicians in the Armed Forces at a continuing high level.

### 10,700 MD's by July, '55

If mobilization continues at presently announced levels, we can expect by July 1, 1955, to have Armed Forces at a strength of 3,356,000. To provide physicians for this troop strength would require 10,700. With 4,000 regular officers, this would require an additional 6,700 reserve physicians. Since the required tour of duty is two years, we can assume that this 6,700 will include all of the physicians called to duty since July 1st of this year, plus enough to bring up the total to this level.

Some 1,200 physicians were expected to enter active duty in July of this year. To meet the remaining two-year requirement of 5,500, there are available an estimated 1, 750 men in Priorities I and II, 2,500 men with double liability in Priority III (including graduates of the class of 1953), and 500 graduates of 1954 who will go into military internships. With few exceptions, everyone going in this year is already in. No calls are expected to be necessary before the late summer or early fall of 1954.

So far then, the available supply totals 4,250 against a requirement of 5,500. The difference, if it is to be met, must come from Priority III physicians in their 30's—those beyond the double liability age group. We feel very strongly that every effort should be made to avoid calls in this group for anything short of full mobilization. Dipping into this age group is bound to come. Serious dislocations and hardships in the fields of civilian service, basic research, and medical education will inevitably come no matter how carefully such calls are planned.

### Utilization Improved

This possibility can be avoided if one of two things happens; if the Armed Forces will continue their already splendid achievements in utilization and bring the total physician ratio down just one point below 3.0 to 2.9 physicians per 1,000, or if there is some further reduction in the total military strength to a figure in the neighborhood of 3,000,000. In January, 1953, the Health Resources Advisory Committee recommended to the Secretary of Defense that a ratio of 3 physicians per thousand troops could be achieved without lowering the quality of care.

Even though they applaud the accomplishments of the Armed Forces, there is still a deep feeling in the professions that further economies can be made without lowering the fine quality of service. This feeling is based on analysis of reports from discharged officers, personal communications to individuals and professional organizations and observations of some military consultants.

This feeling is heightened by the continuing reports of communities desperate for professional services, from industry, state and local public health services, mental hospitals and sanitoria with position vacancies unfilled and patient needs unmet. These facts when coupled with the realization that the proportion of non-

# Medical Society Stand Cited in Column on Legislative Lobbying

Madison, Jan. 12.—John Wyngaard, Madison reporter for the Sheboygan Press, and columnist for a number of Wisconsin newspapers, recently commented on the report of the State Medical Society's Committee on Public Policy. The comments were printed in his column "Under the Dome," in which he reports on capital doings.

WYNGAARD

Referring to the Committee on Public Policy as the "political action arm of the society," Wyngaard said "Representing as it does one of the best organized, most articulate and most responsible professional groups in Wisconsin, the committee speaks with a persuasive voice in the halls of the Wisconsin Legislature.

"Yet its report shows a certain resentment about the popular impression of legislative 'lobbying,' so called. Indeed, the disrepute into which 'lobbying' has fallen in this era seems to worry the society a good deal. It seems to be saying that there ought to be a distinction, in the popular political vocabulary, between the 'good' lobbyist and the 'bad' lobbyist."

Wyngaard quotes from the society's report, saying that "lobbyist" is an odious term "because it implies a type of individual who is mentally pictured as skulking about legislative lobbies and corridors, mysteriously conveying messages here and there. He is always thought of as being 'up to no good', conferring in cloakroom fashion over some mysterious subject in which he, no doubt, possesses an ulterior motive, with some formidable and unworthy purpose in mind."

According to Wyngaard, "the typical and wholesome lobbyists, including those of the society, are concerned with providing information.

"True, they provide some entertainment for legislators, including dinners and luncheons. But that is mostly because meal-time is the most convenient and sometimes the only available period for such discussions between responsible representatives of private groups and the members of the legislature who are concerned with their problems as public problems.

"In the field of public health, for example, only the medical profession is fully qualified by training and experience to advise the legislators who make the rules and write the laws governing public health problems, it is said.

"There will be a certain sympathy for that defensive viewpoint. But those groups that have collided politically with them—such as the chiropractors, the masseurs and others that have differed with the doctors on public health legislation—are likely to disagree, and violently."

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veterans is steadily rising in each year's graduating class and that two years from now, if the belts of military utilization could be tightened just a notch and the size of the Armed Forces does not increase, it should be possible to meet the military requirements from this source.

If, by then, with the cooperative effort of the professions, the teachers and the military, we can achieve at least some of the objectives set by the Armed Forces to make careers in the medical service more attractive, our goals might well be achieved. These goals are (1) a stable, dynamic, regular corps and (2) an orderly plan of reserve increment that would provide a continuing supply of professional personnel at the appropriate levels of training from those liable under the basic draft law.

# MEDICAL FORUMS BEING HELD ALL OVER COUNTRY

Madison, Feb. 12.—The medical forum idea is snowballing throughout the country as medical societies and newspapers join forces to bring their communities up-to-date health information.

Here's a brief resume of typical medical forums which may offer your society the added stimulus for carrying out an extremely successful public relations program.

The Wayne County Medical Society in Detroit recently completed a series of eight public forums in cooperation with the Detroit Free Press. Subjects discussed included heart disease, arthritis, cancer, high blood pressure, common colds and allergies, miracle drugs, and problems of indigestion.

In Columbus, Ohio, the local Academy of Medicine and the Columbus Dispatch held four forums, each opened by a physician and conducted through a panel of four other physicians and a moderator.

To publicize eight forums sponsored by the Vanderburgh County Medical Society and the Evansville, Indiana, Press, front page photographs of participating doctors were carried by the paper along with stories. Added to the typical forum subjects were such topics as sinus disease and tonsils, the role of psychiatry in the community, overweight and health, and ulcers and indigestion.

Other medical forums have been held in Tulsa, Oklahoma; St. Petersburg, Florida; Nashville, Tennessee; White Plains, New York and the like.

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# GERMANY REPORTS 4,500 M. D.S NOT PRACTICING

**This unusual article, reprinted from "The Bulletin," a weekly survey of German affairs, issued by the Press and Information Office of the German Federal Government, is certain to be read with some interest and amazement by Wisconsin physicians. The article was submitted to the State Medical Society by Dr. R. G. Arveson, Frederic, chairman of the Council. It will be printed in the Medical Forum in two parts.**

Meticulous as they are, the statisticians have found 4,543 physicians in the German Federal Republic who are either unemployed or working in jobs foreign to their profession. Certainly, not for all 4,543 is starvation imminent; nor is the percentage of doctors working in construction, in jazz orchestras or in a circus quite as high as some newspaper reporting would have it. It is, however, sad enough when, after many years of training, high hopes for the future dissolve in the face of hard reality.

### Half Are Practitioners

We visualize the doctor as a free person, ready to give help and advice at any time—a man who will receive us in his office and who will come to ease pains and heal wounds if need be at three o'clock in the morning. Actually, however, only half the physicians in the German Federal Republic are independent practitioners or specialists. The question has been raised whether this is a necessary and salutary condition.

Obviously, some physicians have to be employees or civil servants in hospitals and research laboratories, in university training, in public health, health insurance and the pharmaceutical industry. Also, many a future medical practitioner will tend to take such work for a while in order to get experience before "hanging out his shingle."

However, it begins to provoke concern when the above-mentioned group of physicians who are unemployed or working at other jobs, plus those waiting in ill-paid medical work for a chance to set up a practice amount to 18,000 in all. For behind these 18,000 there is another group waiting—the 8,000 postgraduate medical students working as internes and the like for no pay whatsoever. Together they form an intellectual reserve army of a size which seems out of all proportion, its members existing meanwhile at a low standard of living.

Experience has shown that only about 5,000 of these 26,000 medical men wish to remain or become employees or civil servants. Every year, about 800 private practitioners die, but at least 200 of them have a son or relative who steps into their practice "outside of competition".

In addition, there are numerous physicians who are refugees from former German provinces in the East, and every day brings a few more doctors from the Soviet Zone, fleeing to West Germany withou so much as a stethoscope in their pockets. These expellees and refugees also deserve to be given a chance to compete successfully.

The question may well be asked why these thousands of physicians do not try their luck, why they do not simply risk starting the life of a private practitioner.

In Germany, since the days of Bismarck, there has been a system of public health insurance which, far beyond the boundaries of Germany, has been considered exemplary. It was planned to provide the necessities of life to the underprivileged when they fell ill and to make medical care available to them. Today four out of five families are insured under this system, although it obviously cannot be said that four out of five families are "under-privileged".

### Insurance Is Compulsory

Generally public health insurance is compulsory up to a monthly income of 600 Marks (voluntary continuation being permissible). The premium is computed on the basis of the amount earned; half of it is taken out of the earner's pay and the other half has to be paid by the employer. In addition, a patient pays half a Mark for a so-called "sick-ticket" when he wishes to visit a doctor.

Thus, eight out of ten people enter doctor's offices with "tickets". Can we assume that the two patients who visit a doctor without a "ticket" are going to be able to support several thousand free practitioners? Hardly, Especially since at least one of these moneyed patients will without doubt take his ills to a "Professor" —namely, that kind of physician who, besides drawing a fixed income at the university and possibly as head of a hospital as well, will put his outstanding ability and knowledge at the disposal of a few private patients—naturally at an appropriate fee.

Close to the problem is the fact that permission to treat public health insurance patients is not given to all physicians who have been admitted to the profession.

In general, public health insurance does not pay the doctors directly for the medical care of the patients with "tickets". Instead, it pays a lump sum every three months to the Association of Public-Health-Insurance Physicians. The amount is usually not computed on the basis of the number of cases of illness in a given district, but on the amount of health insurance paid in that district. The physicians divide the lump sum among themselves.

### Sum Remains Same

The lump sum remains approximately the same, while illness is to some extent seasonal. During harvest time few people in the country consult a doctor. During an epidemic of, say, influenza, on the other hand, doctors work themselves half to death without getting more for their trouble than in normal times.

Such conditions call to mind a system formerly used in China. His Majesty's physician would receive a salary as long as His Majesty's health remained unimpaired but not a penny as soon as His Majesty became ill. By such methods, the doctor tends to become a victim not only of the physical weaknesses of his patient but also of the latter's moods and neurotic tendencies.

As a result, much of the uneven incidence of illness is a burden carried by the doctors. On the other hand, the system provides the doctors with the advantage of always being sure of a certain income. It is not the system itself which should be blamed for the fact that each treatment, on an average, pays the doctor less than the "pauper's tariff" of bygone decades.

## *BROWN-KEWAUNEE-DOOR SOCIETY PUTS EVERYBODY TO WORK ON COMMITTEES*

Madison, Feb. 12.—Virtually every member of the Brown-Kewaunee-Door County Medical Society is a member of one or more committees during 1954.

More than 100 members of the Society participate in the committee activities in the three county area. Dr. G. B. Merline, Green Bay, president of the society, reports that its 24 committees cover every sphere of medical and related health activities and provide an opportunity for every physician in the county to contribute something to the improvement of the profession and the betterment of public health.

### Has Many Committees

The Brown-Kewaunee-Door County Medical Society has committees on programs, public relations, press relations, legislative and public health, censors, grievances, cancer, fee schedules, mental health, hospital relations, county institutions, libraries, industrial health, chronic diseases, pensions, veterans affairs, rural health, blood procurement, vision and hearing conservation, Brown County Welfare Council, civil defense, maternal welfare, and nursing education. In addition, there is an advisory committee consisting of the president, vice president, president-elect, secretary-treasurer, two delegates, past president and councilor.

Not only does the large committee structure permit new members to be introduced immediately into society affairs, but it permits all members to utilize their talents to the greatest advantage.

### Follows Recommendations

The Brown-Kewaunee-Door County Medical Society committee structure follows very closely a recommendation made by the committee on Grievances and adopted by the House of Delegates at the October, 1953, Annual Meeting. This recommendation stated that "to the extent possible and practical, new physicians be acquainted with activities of the Society through assignment to a working committee of the local organization, possibly in some limited capacity."

The county society, according to Doctor Merline, publishes a list of the committees and committee members with telephone numbers and circulates the list to all members of the society so that each may know whom to contact in the event he has a problem or question.

DAWN MILLS

## Society Gets Thanks From 4-H Trip Winner

Madison, Feb. 8.—The State Medical Society has received a letter of thanks from Miss Dawn Mills, Viroqua, for her trip to the 4-H Club Congress in Chicago.

Seventeen year old Miss Mills went to Chicago on a $100 scholarship provided by the society. This grant is made each year under supervision of the Council on Medical Service as a part of its program to stimulate better health by means of 4-H work.

Miss Mills, a member of the Mills North Springville 4-H Club, has been in charge of her club's health program. In this capacity, she gave reports on heart disease, polio, immunization, undulant fever and rheumatic fever. She arranged a health poster contest, a physical examination project, and a dental health project. She arranged for testing by the State Board of Health of the wells of all the families of club members. She has also plugged for proper nutrition, good posture and safety work.

"I want to say I really enjoyed my Chicago trip," Miss Mills wrote. "It surely was worth working for. I would like to urge every 4-H boy and girl to try to win this fine trip."

## Attractive Reception Room Is Asset to MD

A patient may get his first impression of a physician as he enters the reception room. Have you ever walked into your reception room and tried to see it as your patients see it? Is the atmosphere cheerful rather than depressing?

You don't have to hire an expensive decorator to redo your waiting-room. Nor do you need to spend a great deal of money on furniture, carpeting or drapes. Decorate your reception room in harmonious colors, bright but not gaudy. A tidy, comfortable and attractive reception room shows patients you have their welfare at heart.

Here are some tips for cutting tensions produced by waiting to a minimum:

1. **Decorate your reception room tastefully and attractively.**
2. **Obtain comfortable furniture, adequate for the peak number of patients to be accommodated each day.**
3. **Arrange furniture for reading, writing and conversation.**
4. **Make sure the room is well ventilated and the temperature is regulated.**
5. **If possible, arrange storage space for coats, hats, rubbers and umbrellas to reduce clutter.**
6. **Provide an assortment of up-to-date magazines and light reading material. Place magazines in leather-bound covers to preserve them temporarily.**
7. **Provide adequate reading light.**

That "something extra" pleases patients. Some physicians put up bulletin boards presenting health educational and other interesting subjects. Others place writing desks in the reception room for patients' convenience. You may want to arrange a children's corned with small furniture and children's playthings.

Some doctors have found TV helpful in keeping children occupied. Pictures, posters and plants lend added charm to a reception room. Other doctors suggest using fresh flowers occasionally, installing a lighted acquarium or piping in restful music. Make your reception room as pleasant as possible for your patients.

(Note: This article was reprinted from the new AMA Public Relations Manual.)

## *COOPERATIVE HEALTH INSURANCE PLAN OF MILWAUKEE SEEKS FUNDS, MEMBERS*

Milwaukee, Jan. 2.—The proposed Cooperative Health Insurance Plan of Milwaukee has started a campaign to line up 15,000 members, the minimum number it has set for beginning operation. Initial working capital will be a minimum of $100,000.

The plan, according to Civil Judge Myron L. Gordon, head of the sponsoring committee, is modeled on the health insurance plan of New York City which serves about 400,000 persons in that area.

Members will receive "comprehensive medical care," according to the sponsors, at medical centers from doctors practicing in groups. The monthly rate will pay for the medical services they receive. The doctor groups will decide how they are to be paid by the plan, but it will probably be by salary.

The plan will not cover care for acute alcoholism, drug addiction, dentistry, mental illness, tuberculosis, conditions covered by workmen's compensation insurance, and service-connected disabilities of veterans.

A tentative enrollment of 3,000 members has already been obtained from a local union, and the committee reports that about a dozen Milwaukee physicians have shown an interest in participating.

CHIP rates will be $3.56 per month for unmarried subscribers, $7.12 for those who are married, and $10.68 for families of three or more. In addition, members will be required to carry Blue Cross or equivalent hospital care coverage.

D. Reid Ross, Whitefish Bay, has been named executive director of the plan. He holds a master's degree in socio-economic planning from the University of Chicago, and has studied medical care plans in England and Europe.

The sponsoring committee includes Mrs. Richard E. Krug, civic leader; Mrs. Otto L. Falk, a director of the Community Welfare Council; Rev. Reinhart B. Gutman, executive director of Neighborhood House; Henry S. Reuss, school board member and a former candidate for mayor of Milwaukee and Senator from Wisconsin; J. F. Frederick, Federated Labor Trades Council secretary; William V. Kelley, executive secretary of the Urban League; Harold Schrubbe, Milwaukee County CIO community services director; and Arthur J. Altmeyer, former U. S. social security commissioner.

Medical advisers to the plan are Dr. George Baehr, medical director of the New York plan, Dr. James Howard Means, former medical director of Massachusetts General hospital; Dr. John O. McNeel, Medical director of St. Louis Labor Health Institute; Dr. Robert E. Rothenberg of the New York State University medical faculty and chairman of the medical group council of the New York plan; and Dr. Dean A. Clark, director of the Massachusetts General Hospital, and a member of the Truman Commission on the Health Needs of the Nation.

The enrollment campaign will be carried out through the summer and sponsors expect the plan to go into operation next fall.

## Tormey New Secretary Of Medical Examiners

Madison, Feb. 15.—Dr. Thomas W. Tormey, Jr., Madison, has been named secretary of the State Board of Medical Examiners. His appointment was effective January 1.

Other officers of the Board are Dr. J. W. Prentice, president, Ashland, and Dr. Millard Tufts, vice-president, Milwaukee.

The State Board of Medical Examiners now has offices in the State Office Building in Madison. Its address is One West Wilson Street, Madison.

At the board's meeting in January, nearly 40 physicians received oral or written examinations for licensure in Wisconsin. An additional 15 physicians from foreign countries were interviewed and granted temporary educational certificates to take postgraduate educational training at the University Hospitals. All of these individuals indicated they would return to their native countries as soon as their training was completed.

## Team of Nurses, MD's Can Take Courses in Care of Prematures

Madison, Feb. 10.—In the hope of saving more prematurely born babies the State Medical Society's Division on Maternal and Child Welfare is instituting a series of short courses in the care of the premature.

These courses will emphasize the need of team effort in giving the premature the best possible care. Instruction will be given to no more than three "teams" at a time—six people being the maximum number who can assemble around an incubator for close observation. Each "team" will consist of a nurse and a physician.

Representatives may be sent from any hospital outside of Madison and Milwaukee which reported caring for 30 or more prematures during 1952. Courses for physicians and nurses in these two medical centers may be scheduled later.

Instruction will be given at St. Mary's Hospital in Madison by Dr. Thomas V. Geppert and Sister Mary Dorine. In Milwaukee, the teachers will be Dr. Kenneth J. Winters and Miss Betty Peterson, R. N., at the Maternity Pavilion of Milwaukee Hospital.

For some reason, the number of premature births has been increasing all over the United States. There were 5,520 in Wisconsin in 1952, or 64 out of every thousand live births, as compared to only 24 per thousand, fifteen years ago.

Of the 5,520, 378 died, with their prematurity being considered the cause of death.

## SOCIETY SEEKS . . .

*(Continued from page 161)*

men's Compensation and the Open Panel program.

3. Endorsement of principles to govern the production of a TV health program along the lines of "The March of Medicine" on radio.
4. Adoption of proposals for the indoctrination of new members of state and county medical societies.

The Council also authorized establishment of a Committee on Industrial Health. Dr. Dorchester will announce appointments to this committee at a later date.

creation, out of the old psychosomatic assets and disabilities, of a new person with a completely new set of relationships both toward himself and toward the significant people in his world. The man who loses a leg may find that his present problems may be rooted in the miseries of the past but now also involve a whole new group of attitudes concerning his abilities and worth. But such relationships, especially in a family group, are not static solutions; instead, there is a constant and subtle interplay of personalities, with progressive emotional readjustments and the establishment of differently oriented and organized family constellations.

Two brief examples will illustrate how the old conscious and unconscious conflicts and emotional patterns are used to crystallize new attitudes to meet the changed circumstances. A middle-aged, apparently adequate man always had a great longing to be dependent and cared for but had never had an opportunity for such consideration because his wife, querulous and always delicate, had "beat him to the draw." When chronic organic illness was discovered, he smilingly and bravely accepted it as his honorable discharge and used his remaining strength to organize a comfortable life of invalidism. This forced his wife to get a job and also to take care of him. Life was completely different for both of them and was characterized by the bitter resentment and irritability of the wife and the placid, determined, and unshakable invalidism of the husband, both of whom were now changed personalities and had an entirely new relationship.

Another patient, an elderly minister who was a John Brown of a man, a driving, powerful, dominating, assured man, had a little, patient, mouselike wife. After the clerygman was stricken by apoplexy he was unable to preach, and the congregation asked the wife to substitute. She died a thousand deaths but suddenly found herself and her message in the pulpit. She returned home a new person, and the elders crowded about the invalid's bed to tell of her beautiful sermon. Somehow the patient was not as uplifted as anticipated. This happened twice again, and now the wife was transfigured, confident, radiant, and decisive, defying her husband when he ordered her to stop preaching. Subsequently, the patient did not change appreciably on any organic basis but did become a different person—bitter, paranoid, depressed, and filled with hatred for his wife and himself.

The foregoing should focus our attention sharply on one of the most important factors in the formation of the patient's present emotional reaction to his illness. To that situation he brings his lifelong attitudes, emotional values, and habitual ways of reacting to stress. He may have staggered along for years with a severe neurosis which has gradually solidified into the character pattern of a difficult person. The intercurrent illness may accelerate the process a little but more often it only discloses to all what should have been apparent before, namely, that the patient is and always has been a difficult and unhappy person. For example, there are those who have gone through life demanding and usually getting what they want when they want it. In such persons there is an unwillingness to sacrifice present satisfaction for a greater future gain and also a refusal to tolerate any discomfort or frustration. They have been able, in one fashion or another, to enforce their wishes in the past and now, whether it is pain or the inconvenience of their illness, they demand that it be removed at once. Their unwholesome attitudes and often harmful demands during illness are only a repetition of a lifelong habit. Other patients may show hostile and paranoid behavior patterns which are inexplicable until it becomes apparent that they have always been this way. Aldous Huxley[2] has described these people as follows: "There are many people for whom hate and rage pay a higher dividend of immediate satisfaction than love . . . Knowing that one self-assertion always ends by evoking other and hostile self-assertions, they sedulously cultivate their truculence . . . But a fight is what they most enjoy; for it is while they are fighting that their blood chemistry makes them feel most intensely themselves. 'Feeling good,' they naturally assume that they *are* good . . . [It] is rationalized as Righteous Indignation and finally, like the prophet Jonah, they are convinced, unshakably, that they do well to be angry." To this may be added that they are wedded to this pattern "in sickness and in health, forsaking all others."

However, the majority of patients do not wear their red badge of neurotic conflict so openly. In our culture, with its premium on being normal or at least appearing to be

average, we all struggle to gain a place on the broad spectrum of the normal range. We do this by presenting an external façade of adequacy, maturity, and emotional stability. But each of us knows that, at least for himself, this imposing front only conceals, we hope, the back storerooms where we hide our anxieties, conflicts, painful memories, insecurities, hates and resentments, forbidden loves and attachments, secret needs, evils, wickedness, and guilt. Of course, we know that the same is true of others, but there is a tacit and secret pact that we will all "make believe" that such is not true for any of us. And most of the time we can maintain this pleasant fiction even though we realize at times that the emotional balance is in uneasy equilibrium. As long as we maintain metabolic balance, are not subjected to an emotional overload or a serious threat to our body image, our defenses remain intact and adequate. But, in many, it is not a defense in depth but a pitifully thin line which is overrun in the first assault of the invading illness. Then the chronically anxious and insecure ask themselves how they can meet this threat, what will become of them and of all those who depend upon them. Others with meager resources may surrender openly to the depressive syndrome they have long hidden within themselves. Guilt may overwhelm them with unspoken remorse about what they have done to others or even how they have brought this trouble upon themselves. Some may utilize hostile aggressive mechanisms relating to underlying attitudes concerning what others have done to them, how the illness was really brought on by others through a lack of love and consideration, or how they have thus destroyed themselves for the benefit of others and for what niggardly recompense. Intermixed with all combinations of the above is frequently a confusion concerning the religious and spiritual concepts of life and death and invalidism, and the personal meaning or lack of meaning the troubled patient can give to it.

In ordinary life, the defensive and inhibiting mechanisms are sufficient to keep the deeper emotionally charged conflicts under control. Often the material relates to hostile and resentful feelings toward those we love. That we may entertain hostile feelings toward those we love should not seem strange to even the most casual observer of life. Even a loving wife, after an overly optimistic and certainly ill-advised fifth Martini, may express herself in a way which might be interpreted as hostile. It soon becomes obvious that her meticulously documented and carefully annotated remarks could not spring *de novo* from the olive but only from long rumination and deep resentment. The sadistic glee expressed by an ordinarily dutiful son when father slips on the ice and lands with a spine-shattering crash would indicate that the offspring entertains at least a mixture of feelings. The father should not receive too much sympathy because he is quite able to reciprocate these familial feelings, and does.

But in illness, and especially in chronic illness, this complicated interplay continues and frequently eventuates in the struggle for mastery. The patient, by exaggerated pathos and suffering, may gain control over the whole family as an expression of his hostility, which may be based on historical data or on his present plight. Or, the marital partner may move in on the invalid with sweet and solicitous domination but one that brooks no contradiction. Certainly, we have all seen the spouse who will not leave the bedside of the patient, and tyrannically controls the whole situation under the guise of unselfish devotion. We have heard such a controlling wife tell everyone with a little self-depreciative laugh, "Oh, he just couldn't get along a minute without me," and then the iron hand slips into the velvet glove, "Could you, dear?" and the poor fellow answers with all of the quivering gaiety of a snared rabbit, "I don't know what I would do without you," and several psychiatric interviews later completes the sentence, "But I'd sure like to find out."

Even more frustrated and depressed was the patient who secretly believed that his wife's frigidity was an important etiologic factor in his chronic and painful illness. He was denied even the solace of resenting her when she nursed him tirelessly and unselfishly for months during an acute exacerbation. He was left with no other method of expressing his emotional conflicts except by self-hate and depression. Truly, as Hammerschlag says, "The multiplicity of human nature unfolds itself in some of its richest colors under the impact of physical disease."[3]

### Emotional Factors Related to the Physician

But even the above emotionally provocative factors do not encompass the total set

of influences reacting upon the patient. Usually such a patient is at some time or another in a hospital setting where he is exposed to the emotional climate of doctors and nurses who take care of him. There are many criticisms which may be justifiably leveled at some doctors, although in the same breath it should be admitted that there are also a great many who are very deft, understanding, and skillful in recognizing the needs of their patients. Only a few medical fallacies may be mentioned in this short discussion.

First of all, doctors still unconsciously associate the size of the patient, his general appearance, and muscular build with a concept of adequacy. To be large is to be adequate. It is always a matter of considerable surprise to many clinicians when a large, handsome, powerfully built man suddenly begins to act in a childlike manner. His record of business successes, his imposing physical appearance and dominant manner delude the unwary into the belief that we are here dealing with a thoroughly mature individual. They so often forget that such an imposing façade only cloaks and attempts to heal over the inadequacies, inferiorities, and fears of a very large child.

The second mistake is the delusion that neurosis wears its own expression. Too often we hear, "Why, this patient didn't look the least bit neurotic." Probably the most difficult lesson to learn is that human beings attempt to hide the fact that they are troubled, bewildered, and confused. They do so behind a poker face and a long record of community achievement, but these only represent tremendous determination and overcompensatory efforts to overcome those things they feel are wrong with themselves. There are many individuals living ordinary lives in the community who cover up, either because of pride or dignity, the many weaknesses, inadequacies, and apprehensions which are the heirloom of our present culture. So many strain at every fiber to maintain this appearance that often it is not realized how many are near the breaking point. The catastrophe of an acute or chronic medical or surgical illness is often the final straw that breaks the camel's back.

Finally, on the part of the physician, there is an unbelievable misconception of the medical sophistication of the average citizen. Led astray by the many medical articles in the lay press, the physician often feels uncomfortably that the patient is a short step behind him in medical knowledge and is literally panting down his neck. Because physicians need to be secure and because it is necessary to impress the patient with their ability to care for this serious situation, they discuss the medical aspects of the patient's problem in terms completely unintelligible to the patient. Probably psychiatry has led the field in contributing supposedly scientific terminology to the vernacular of the populace. A tremendous amount of scientific knowledge is necessary to understand even the simple medical problems. Yet physicians often blithely assume that they are talking to a contemporary specialist in the field and, therefore, explain complicated medical and surgical problems to patients in such a way that they are entirely incomprehensible. In internal medicine they discuss with patients the developments in steroid chemistry which may be expected next month, while in surgery they discuss renovations and rearrangements of the upper part of the abdomen which could reasonably be expected to baffle an anatomist. But the patient, so glad for the personal attention and the camaraderie expressed by such an interview, nods his head sagely, forms a hundred misconceptions, and finally comes to the conclusion that whatever is wrong with him is certainly awful and is only equalled in complexity by the cure that is being proposed.

Physicians must realize the wisdom of an old saying, namely that people stand anything better than they stand uncertainty. Physicians must learn also that explanations must be couched in terms understandable to the patient, in similes and metaphors that relate to the patient's knowledge and experience, and that the explanations should appeal to his common sense, to a logical plan of attack, with overtones of an expectantly hopeful solution. This was most clearly brought to mind recently by an emotionally upset postoperative patient who complained bitterly that the surgeons had been tampering with her female organs. She demanded an explanation for a previous operation and was especially concerned to know why uterine surgery had been done. At this juncture she triumphantly demonstrated a gallbladder incision and pointed out that she had not functioned normally as a woman since they had removed her uterus. It must be ad-

mitted that she was no intellectual giant, but on the other hand, it is equally fair to suspect that there was a definite breakdown in communication between the patient and her surgeon.

### Emotional Factors Related to the Nurse

And then there remains the problem of the nurse who is in close association with the patient, and who either satisfies or creates emotional needs. In the opinion of the essayist the full realization of the emotional functions of the nurse has remained one of the great blind spots in the eyes of the medical profession. Created as a handmaiden, molded into a silent and efficient piece of machinery, polished in the performance of a group of mechanical tasks, the personality and the womanliness of the nurse have long remained a neglected aspect of her person. Nursing educators have become progressively more aware of this aspect of the nurse and the contribution which she may make in her own very special fashion, which is not particularly related to her mechanical abilities. They have had insufficient support from members of the medical profession, who all too frequently have regarded her as a convenient, well-shaped tool for the carrying out of specific functions. However, the nurse's major contribution will often be her emotional relationships with patients; or she may detract equally by her lack of such relationships. It is not important whether we agree with one school which maintains that to the patient the nurse represents a reincarnation of a mother figure, either good or bad, or whether the patient regards the nurse as a human being who is assisting him, nursing him, and caring for him in a moment of helplessness. The point is that a nurse either may or may not contribute, according to her own personality, in fulfilling the emotional needs of the patient. In order to avoid the suspicion of being maudlin on this subject, let every doctor examine his own memory and find out if on certain mornings the majority of patients are not upset, irritable, complaining, and uncomfortable after Miss X has been the supervisor of the floor during the night. He will find that certain nights are characterized by repeated sedation, complaints, and crises; and he will find further that the answer to these difficulties lies in the personality of his night supervising nurse. This is not meant to criticize the nursing profession but rather to emphasize the need for understanding and leadership by physicians in this most important area.

### Mechanisms for Dealing with Intolerable Anxiety

Now we have our patient involved in a Laocoönian struggle, not only with his past emotional relationships, personality defenses, and habitual patterns of reaction, but also with his present situation, immediate disease, and a complete incomprehension of what is about to happen to him either physically or spiritually. In such a situation, there are a few sthenic souls who deal with it unflinchingly. Most of us are not able to summon such reserves, but instead react with intense anxiety which, in those who are already carrying a heavy load, becomes an intolerable burden and one about which something must be done. Everyone who has experienced intense anxiety will realize that this represents an emotionally and personally disorganizing experience which can be tolerated only for a certain span of time. After this time, and the length of this period will be dependent upon the reserves of the individual, something must be done about it.

Probably one of the most basic mechanisms of dealing with such intolerable anxiety is obliteration of the usual inhibiting mechanisms and a relinquishment of adult behavior. Whether this represents a down-the-ladder retreat into previously utilized mechanisms of childhood or whether it is merely a loss of the inhibiting mechanisms which hide the childishness in all of us is a matter of little consequence here. The essential point is that in the face of such intolerable anxiety the patient thinks, feels, and reacts as a child. This may manifest itself in many ways, all of which are eventually disturbing to the physician in charge. One method is by the utilization of childish mechanisms of irritability, tantrums, unreasonable demands, capriciousness, insistence on ritualistic patterns of treatment, and even demands for special attention and affection from the physician, nurse, and family. All of these are annoying to the busy physician who is already faced with more than he can do and now finds that he must endure all of this unreasonable childish behavior. It should be realized that this behavior pattern is not designed specifically to annoy the physician and nurses, but

rather represents a reaction on the part of the patient to attain a situation in which he may feel secure. During the crucial period a good deal of indulgence and latitude may be allowed. After all, growing up is not a matter of a few minutes; and therefore a patient who is helped over this most difficult time by patience and understanding may again achieve the maturity which he previously possessed before being overwhelmed by anxiety. We may be sure that he will not achieve it instantaneously by an authoritative demand to "grow up."

Other patients will utilize aggressive or childish mechanisms in an even more subtle manner. They become very well-behaved children. In their manner there will be a childish submissiveness and respect for their attendants, a technic of ingratiation, because by perfect behavior they will win the affection and, therefore, the excellent care of those who are now essential to restoring them to health. They become perfect patients and to the distraught nurse and busy doctor, at the outset, they represent a pearl without price. It is only later that the physician finds that he has been manipulated into a situation of dependency where the patient is now forever unwilling to grow up again. The unwary physician or surgeon has unconsciously expected that the childlike, perfectionistic dependency will stop on a certain day and is dismayed to find that what originally started with a transitory parent-child relationship has now developed into a permanent adoption. He now experiences all of the difficulties of a mother robin trying to shove a large baby robin out of the nest. Each effort to break the bond suddenly now causes a recrudescence of symptoms, complaints, and assorted syndromes designed to maintain the relationship on a permanent basis. If the bond is broken abruptly, the physician who has hitherto experienced only the complete devotion and affection of his patient is surprised to find a tremendous change in the patient's attitude. He must remember that when a child has been given a tremendous amount of love and affection and this is suddenly withdrawn, it will be replaced by an equal hate. Thus, he is amazed and embittered to find that one of his most devoted patients has now become one of his most implacable enemies. Again, he has overlooked the fact that he has been dealing with a situation, not between two mature adults attempting to solve a problem, but rather between a parent and child in which the child was desperately frightened and needful.

This same dependency situation may be manifested in regard to the family rather than to the hapless physician. In one instance, a middle-aged woman had experienced nothing but trauma, rejection, and even frank brutality from the hands of others since early childhood. Because of her desperately insecure position, she learned that her only solution was to work as hard as she could, never complain, never be openly hostile or resentful, and never ask for anything in return. In this way, she could at least hope for a marginal existence in which she was given some love, some security, and a home. She utilized this pattern throughout all of her life and overworked herself, took a job outside of the home, put up with inconsiderate behavior from her husband, found that her children exploited her, and yet swallowed all of her resentment and bitterness with the thought that she was lucky to have as much as she did. Finally, a hysterectomy was necessary and was followed by pneumonia. This was sufficient to break her very tenuous hold on compensation, and she underwent a complete decompensatory syndrome characterized by fatigue, exhaustion, emotional depletion, diarrhea, and inability to do all of the things she had done before. As a consequence of the development of this syndrome after her operation, she was utterly amazed at the results. She was able to leave a job which she hated, the children began to do some of the housework, the husband became thoughtful and considerate, and those to whom she had given previously without thanks now rallied about with affection and consideration. The more that this situation prevailed, the sicker she became and, as a bonus for this syndrome, she was now able to be snappish, irritable, and resentful and everyone smilingly wrote this off as only a part of the irritability of an invalid. The final picture cannot be explained in terms of metabolism nor in terms of adhesions, but may be understood only in the words of a recent political aspirant, "You have never had it so good."

The subject of dependency cannot be dismissed without at least a brief word regarding drug dependency. As has been pointed out by Rome,[4] the medication easily becomes a symbol of the doctor. It is his function to

relieve pain and to ensure relaxation and comfort and, in his absence, something of him may be given in a symbolic form, namely in the form of a palliative medicament. Thus, many patients faced with problems and overwhelming anxiety will, in a dependent fashion, demand more and more of the physician, who attempts to relieve this demand in a common-sense manner, namely by the administration of drugs. To him, it is only a matter of pharmacology but, in a deep sense to the patient, it is a matter of literally giving a part of himself and a part of his professional skills in the symbolic form of medication. Thus, many patients, long after the objective need for such relief has disappeared, will continue to demand treatment and medications almost as a proof of the physician's continuing interest in and treatment of them. It is bad enough when such medications are only placebos; but when there are associated dangers pharmacologically and psychologically, as with some of the more powerful narcotic medications, a secondary problem of addiction may soon arise. This represents only another facet of the dependency syndrome and the need for alleviation of intolerable anxiety.

It would not be difficult to continue almost indefinitely with the need of the patient to relieve himself of anxiety and the numerous mechanisms employed for such relief. Only one other major technic of relieving anxiety will be discussed at this time. This is the method of discharging anxiety by its conversion into various hostile mechanisms and the discharge of this hostility into the environment or into the self. In many patients there is already a tremendous fund of hostility engendered by all of the slights and miseries of the past. To this is now added the bitterness of the present moment and this is especially prominent in chronically ill patients. The anxiety and rage regarding the past and present form a sort of reverberating circuit, and finally the total summation is experienced as a tremendous apprehension and resentment concerning what is now happening and what will happen. With decompensation in some organ system, the patient cannot avoid bitterness toward all those who are now healthy, happy, and untouched. Some of this may be due to actual envy, but much more of it relates to resentment over why the individual person should be the one so afflicted.

But how can one handle such hostile and bitter resentment? To turn it inward only means depression and more suffering. Some patients do utilize this course and as a result are overwhelmed by their depressive syndrome, their hopeless feelings of futility and self-hate. Others, however, find that they must discharge this tension in a more vigorous fashion. It does no good to beat with one's fists upon an arthritic knee or to hate a decompensated heart, but on the other hand, it does become possible to slyly and cleverly hurt others in the environment. It does not make any particular difference who it is, anyone will do—the wife who has not been as considerate as she should have been or, if she is not sufficiently available, the nurse will do equally as well. Even the physician may be a good target for this hostility. Patients do find that at times it relieves their intolerable anxiety to hurt those about them, especially if they observe that the other person, the family, or medical attendants are wincing painfully. With a little reflection they usually are remorseful and again anxious to utilize more socially accepted modes of behavior but, for the moment at least, it does seem good to see someone else hurting and as miserable as they.

Here again we enter into a reverberating circuit, because families, nurses, and doctors do not accept these attacks upon their egos, technical skills, and personalities without reacting to them. Most of these patients, with an almost uncanny skill, seem to probe about until they strike a tender nerve in our personalities and when this is sufficiently stimulated, we begin to react to the patient with defensive, hostile mechanisms of our own. This is exactly what the patient desires. It no longer becomes a matter of a causeless and senseless attack on the patient's part; but now he is an individual defending his rights; standing four square for justice; seeing the battle to the finish with the nurse regarding hospital regulations, frequency of medication, or whatever *casus belli* is convenient. Allies are now enlisted, evidence is marshalled, and the Rights of Man are invoked. It soon becomes an internecine struggle of hurt feelings, and the battle lines become drawn on nonexistent issues because neither the patient nor those attending him realize that this is indeed a "phony war" and only represents a convenient discharge for the patient's tension, anxieties, and miseries.

Unfortunately, too often doctors and nurses react to these situations as human beings instead of as doctors and nurses.

### What Can Physicians and Surgeons Do?

And now it is reasonable to inquire as to what physicians and surgeons are to do about all this. It has been my task to delineate the needs of these patients, and space does not permit a detailed discussion about meeting these needs. Only a few critical generalities may be offered. First, in spite of lip service to psychosomatic principles, too many physicians are still imbued with a mechanistic concept of illness, namely the disease and the patient in conflict. This implies that two opposing physiologies, one for life and one for destruction, are locked in deadly embrace, with the patient supplying a sort of inert, unresponsive gridiron for the struggle. Second, as an outgrowth of the first, there is too little understanding of the frightened, childlike qualities of the patient; and when he acts like the child he is, the behavior is regarded as capricious, ungracious, selfish, and irritating. It is only by discarding the first premise and unreservedly accepting the second that the physician can approach the problem with intelligent compassion. Third, the busy life of the physician and his own personal reserve often prevent him from giving as much time and as much of himself as the patient needs. To the patient the visit of the doctor and what is given medically and spiritually constitute the important event of the day or week. Too often he is expected to survive until the next visit on a broth too thin for nourishment. Finally, the greatest problem of physicians is a unique type of disturbance of understanding, that is, not talking that patients may understand them and not listening that they may understand their patients.

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Mayo Clinic, Rochester, Minnesota.

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## AMERICAN COLLEGE OF SURGEONS OFFERS SCHOLARSHIPS IN FIELD OF RESEARCH

The board of regents of the American College of Surgeons has announced the establishment of scholarships in the field of research for young men seeking a career in academic surgery who have recently finished or are in the final months of their residency training program.

In May the college established one of these scholarships. It is planned that additional scholarships will be added through the efforts of Fellows and various organizations interested in this project.

Candidates must obtain the approval of the chairman of the department of surgery and dean of the same medical school and the authority of an executive officer of the university making the proposal.

Successful candidates will receive $20,000 over a three-year period, to be divided as follows: $6,000 for the first year, $6,000 for the second year, and $7,500 for the third year. The institution or medical school sponsoring a successful candidate may supplement this amount with the permission of the committee on selection of the American College of Surgeons.

Medical schools or institutions supporting the nomination of a candidate will be required to provide a satisfactory place to work, with adequate facilities, as well as funds with which to support necessary research.

The candidate and the institution supporting his nomination are asked to supply the college with a planned program for the nominee. On completion of the research scholarship, the medical school or institution supporting the candidacy of the nominee is expected to absorb the research scholar into its faculty and to support him on a full-time basis with its own budget.

Inquiries may be addressed to the Research Scholarship Committee, American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

# The Public Health Nurse in Your Community

## As It Looks to Your State Board of Health

SOME physicians still do not understand the function of the public health nurse in the community nor realize that she is an important member of the team of allied professional workers provided by the community to assist the physician in obtaining complete care for the patient. Along with that of the skilled social worker, the physiotherapist, the child psychologist, and others, the public health nurse's service, when effectively employed, can be a great asset to the physician and his patient. Better understanding of the public health nurse's contribution to medical practice is the first step toward its more effective use.

The county, city, or visiting nurse in your community is a graduate nurse with the plus-value of an up-to-date knowledge of preventive technics, a trained sensitivity to the early symptoms of disease, and a familiarity with the facilities offered by her community and state for all types of physical and emotional ills. The county or city nurse, while not able to give bedside care on a continuing part-time basis as is the visiting nurse, will teach the family necessary nursing skills, help in finding practical nurse assistance, and supervise the care of the patient in the home.

In all home contacts, emphasis is on prevention of disease and the preservation of health through accepted health practices, as well as on early medical care for symptoms indicating deviations from normal. Endless instances of the discovery of vision defects, hearing loss, emotional disturbance, etc., can be found in public health nurses' files—early discovery at a time when satisfactory treatment by the physician is possible.

Specific examples may serve to illustrate other ways in which the public health nurse has been of demonstrable assistance to the physician and his patient.

At the request of the physician, the public health nurse called on a cancer patient who had failed to return for her checkup. After the patient had an opportunity to discuss her fears, the nurse was able to convince her that her best insurance was regular medical supervision.

A newly diagnosed case of tuberculosis was referred to the county nurse by his physician. She arranged sanatorium care for the patient, was able to get family contacts in to the physician's office for examination, and referred certain social needs of the family to the proper agency for attention.

A patient, recently returned from the hospital, was taught how to care for his colostomy so that a life of normal activities was possible for him. His wife was given help in the selection of foods for the family meals.

A young mother with her first infant was referred to the public health nurse through the hospital. Her anxiety and insecurity in caring for her infant might well have resulted in an anxious, fussy baby and miserable parents. By visiting soon after the discharge of the mother and infant, the nurse was able to demonstrate care with home equipment, reassure the parents, and build up their confidence in their own ability to give safe care to the child in an atmosphere of love and relaxation.

Because a diabetic patient appeared at his office with hard painful lumps at the point of insulin injection, a physician asked the public health nurse to visit her. She found that the patient, in her confusion and concern, had been injecting the Benedict's solution! By frequent visits at first, then more widely spaced contacts, the public health nurse not only taught the patient the "how" and "when" of urine testing and insulin injection, but gave guidance on the selection of foods and their preparation as a part of family cookery.

The needs of the military and civilian medical services; the general shortage of nurses, doctors, and hospital beds; and the increasing number of chronic illnesses make the effective use of all available medical services imperative. The individual physician is in a position to encourage the best possible use of the public health nursing services offered by his community. — IONE ROWLEY, R.N., *Assistant Director, Bureau of Public Health Nursing.*

# Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

## Questions and Answers Suggested by Recent Investigations in Drug Therapy

*In connection with drug therapy, what interesting speculation has recently been made regarding the origin of hypertensive headaches?* From Baylor University, John H. Moyer *et al.*,[1] reported a study of 13 patients with headaches resulting from hypertension who were given either 0.5 Gm. aminophylline or 0.5 Gm. caffeine sodium benzoate intravenously in saline. Effects on cerebral blood flow, cerebrospinal fluid pressure, and the headaches were evaluated. Aminophylline caused an average drop in cerebrospinal fluid pressure from 210 to 132 mm.; water and caffeine caused an average fall from 172 to 141 mm. The average rate of cerebral blood flow fell from 53 to 36 cc./100 Gm. brain/minute following administration of aminophylline, but only to 47 cc. after caffeine administration. Jugular venous pressure declined after aminophylline administration but was unaffected by caffeine.

Although the mechanism of hypertensive headaches is not explained fully, the headaches are probably not correlated either with level of blood pressure alone or with cerebrospinal fluid pressure alone. Hypertensive headaches are possibly the result of distention of the cerebral arteries, with pain referred to the cranium. The increased cerebrovascular resistance and decreased cerebral blood flow following administration of the two drugs, indicating cerebral arterial constriction, caused increased tone and decreased distention of the blood vessels. This may well be the genesis of pain relief. Where hypertension in the cerebral vascular system is transmitted to the postarteriolar capillaries, transudation and cerebral edema, with so-called encephalopathic headaches, may occur. Following the administration of aminophylline or caffeine, there are temporary increase in tone and increased cerebrovascular resistance, decreasing arterial vascular distention and resulting in less pressure being transmitted to the postarteriolar capillaries. This favors return of fluid from the interstices of tissue back into the vascular bed, lessening of the edema, and relief from the headache.

*What condition should probably be added to those in which quinidine is absolutely contraindicated?* Although quinidine sulfate reputedly helps prevent or abolish episodes of transient ventricular fibrillation in patients with complete heart block, Sidney P. Schwartz *et al.*[2] find that substantiation of the reports is inadequate. Three of their patients with recurrent transitory ventricular fibrillation were given quinidine orally by one of three schedules—0.2 Gm. hourly, a single dose of 0.4 Gm., and a single dose of 0.67 Gm. The results of all the tests were comparable, despite variation in requisite dosage and intensity of response.

The initial effects were on intraventricular conduction, as reflected by early enlargement and negativity of T waves with prolongation of associated RS-T segments. Simultaneous development of premature beats arising from the ascending limbs of the T waves produced deformed ventricular complexes, known to be forerunners of ventricular fibrillation.

There was a progressive increase in duration of the returning cycles which followed premature ventricular beats that appeared at the same time. When complete heart block is present and the ventricular rhythm is disturbed by an extrasystole, the length of the returning cycle is usually precisely that of the initial cycle. Sometimes the returning cycle is shorter. It has been found to increase in duration after cardiac fatigue, but the increase is precipitated early by quinidine. These alterations indicate increased refractoriness of heart muscle.

Recovery from prolonged ventricular fibrillation is characterized by a protracted period of ventricular asystole succeeded by periodic standstill of the ventricles and atria when the fibrillary process is ended. Quinidine causes these changes to appear earlier than usual; it prolongs ventricular standstill immediately after fibrillation ceases and prevents development of postfibrillary periods of tachysystole, which usually follow the shorter periods of ventricular fibrillation.

The authors believe that quinidine sulfate was responsible for development of recurrent periods of transient ventricular fibrillation that persisted for hours once the mechanism set in after its use. They conclude that it is contraindicated in patients with transient ventricular fibrillation during established atrioventricular dissociation.

This article supports the belief that complete heart block should be added to subacute bacterial endocarditis, angina pectoris that is being relieved by fibrillation, and known sensitivity to the drug to complete the list of absolute quinidine contraindications.

*Enzyme application appears inadvisable in ulcerations following what type of therapy?* Two cases of late ulceration of the anterior chest wall that enlarged during streptokinase-streptodornase treatment were recently reported by S. Gordon Castigliano and C. Jules Rominger.[3] The necrotic material increased in amount in these cases; a febrile reaction developed, possibly from absorption of pyogenic material; the chest wall was almost perforated; and an eczematoid dermatitis occurred, possibly aggravated by increased discharge.

Many irradiated cells whose blood supply and vitality have been impaired are believed to be in a marginal state of viability. Some of these cells forming the base and edges of an indolent ulcer would survive and contribute to the process of repair with ideal supportive treatment, or at least would not interfere with it. But these cells, when in a state of marginal viability, are destroyed and digested by streptokinase-streptodornase, contraindicating enzyme use.—HARRY BECKMAN, M. D.

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# « « « EDITORIAL » » »

## A New Diagnostic Aid

Two articles on translumbar aortography in this issue of *The Wisconsin Medical Journal* illustrate very adequately the advantages of translumbar aortography as an objective diagnostic tool both in urologic diagnosis and in diagnosis of diseases of the arteries of the extremities. It might also be useful in other fields of medicine wherever the vascular pattern of an organ in the abdomen or lower extremities requires visualization.

The technic of the test is not difficult, and its performance should certainly be feasible wherever adequate radiologic equipment and competent personnel are available. Since its first description in 1929 and its recent popularity, thousands of tests have been done with no recorded mortality; and the only morbidity possible is quite negligible.

This important new diagnostic tool seems to this writer to mark one step forward in the more accurate and objective diagnosis of disease, and it therefore makes better therapy possible. We urge every reader of this magazine to familiarize himself with the possibilities of this test.

## Medicine and Pharmacy

For the past several years pharmacy has been increasingly critical of practices of the medical profession, particularly as regards physician-dispensing and clinic-owned pharmacies. Practically all other points of controversy between the two professions have been resolved, and these two remaining points are being worked on by committees of the Wisconsin Pharmaceutical Association and the Wisconsin State Medical Society.

Historically, pharmacy has always been a part of the medical profession; and our earlier colleagues, particularly in the rural areas, had to do their own dispensing because of necessity. As the profession of pharmacy grew and more pharmacists were available, doctors turned over this portion of their work to the pharmacists and encouraged them to build their profession into an independent and self-sustaining one. We all appreciate the services of the pharmacists and desire to help them in every way possible. The A. M. A. has even gone so far as to declare in its code of ethics that dispensing by a physician for profit is unethical and that we are to look for our necessary income from services rendered and not from the barter or sale of drugs,

surgical appliances, or other incidentals to the practice of medicine. Statements like these, made by the medical profession, certainly prove beyond a question of a doubt that we wish to do all we possibly can to help our ancillary profession of pharmacy. However, there are many ramifications of this particular problem. The ideal cannot always be obtained, and probably never will always be obtained, because of many different circumstances such as availability of pharmacists, traditional patterns in certain areas, and the like.

Clinic pharmacies are also a knotty problem. The increase in clinics throughout the state in the past several years has been one answer to more efficient utilization of medical services in certain areas, giving a much more satisfactory type of service than previously and making it much more pleasant and satisfactory for the doctors practicing in the clinic. Physical therapy divisions, dental divisions, and pharmacy divisions are frequently added to the clinic to make the service rendered the population more complete and for numerous other reasons. This poses problems for the pharmacies that are already in existence in these areas.

Both of these problems—physician dispensing and clinic pharmacies—have so many ramifications, and there is so little objective information available that an intensive study is being made, beginning at the very grass roots, by a committee of the Wisconsin State Medical Society, which will delve into every aspect of the problem. When the entire picture can be looked at, an attempt will be made to arrive at some mutually agreeable solution.

Have you the solution? Your comments are invited.

## 1954 COLLEGE ESSAY AWARD

The board of regents of the American College of Chest Physicians offers three awards to be given annually for the best original contribution prepared by any medical student studying for the degree of Doctor of Medicine on any phase of the subject of diagnosis and treatment of chest disease.

The first prize will consist of a cash award of $250 and a certificate. The second and third prizes will be certificates of merit. The competition is open to all medical students in accredited medical schools throughout the world.

The winning contributions will be selected by a board of impartial judges and will be announced at the 20th Annual Meeting of the American College of Chest Physicians to be held in San Francisco, California, June 17–20, 1954. All manuscripts become the property of the American College of Chest Physicians and will be referred to the editorial board of the college journal, *Diseases of the Chest*, for consideration. The college reserves the right to invite the winner of the first prize to present his contribution at the annual meeting of the college.

Applicants are advised to study the format of *Diseases of the Chest*, noting length of articles, form, and arrangement of illustrations to guide them in the preparation of the manuscript. The following conditions must be observed:

1. Five copies of the manuscript typewritten in English (double spaced) should be submitted to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois, not later than March 15, 1954.
2. The only means of identification of the author shall be a motto or other device on the title page and a sealed envelope bearing the same motto on the outside enclosing the name and address of the author.
3. A letter from the dean or chairman of the department of medicine of the medical school, certifying that the author is a medical student studying for the degree of Doctor of Medicine and that the contents of the manuscript represent original work.

# 1954 CIRCUIT TEACHING PROGRAMS

## COUNCIL ON SCIENTIFIC WORK

*in Cooperation with*

THE WISCONSIN STATE BOARD OF HEALTH
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WISCONSIN CHAPTER, AMERICAN ARTHRITIS AND RHEUMATISM ASSOCIATION

## *Dates and Sites*

MARCH 16–17–18: Monroe, Kenosha, Portage

APRIL 13–14–15: Eau Claire, Stevens Point, Appleton

APRIL 27–28–29: Platteville, Oconomowoc, Manitowoc

MAY 25–26–27: Chippewa Falls, Pinecrest (near Iron River), Rhinelander

JUNE 16–17–18: Racine, Elkhart Lake, Menominee, Michigan (as part of two-day program of Upper Peninsula Medical Association)

*Fee:* $6.00 per clinic (including dinner)

*Credit:* 5 hours formal credit for members of Wisconsin Academy of General Practice

*Time:* 2:00 p.m. to 5:30 p.m. and following dinner to 9:00 p.m.

*Speakers:* 10 visiting speakers—10 outstanding in-state speakers (see inside pages for names and topics)

*Reservations:* Make your reservations now, before the matter slips your mind. Use the form provided on page 184.

# Speakers—1954 Circuit Teaching Programs

## Visiting Teachers

EDWARD D. ALLEN: Professor and head of the Department of Obstetrics and Gynecology, Northwestern University School of Medicine

ALLAN C. BARNES: Professor and head of the Department of Obstetrics and Gynecology, Western Reserve University School of Medicine, Cleveland

RICHARD B. CAPPS: Associate professor of medicine, Northwestern University School of Medicine

EDWIN J. DeCOSTA: Assistant professor of obstetrics and gynecology, Northwestern University School of Medicine

THOMAS J. DRY: Associate professor of medicine, University of Minnesota Graduate School, Rochester, Minnesota

ROBERT L. JACKSON: Professor and head of the Department of Pediatrics, State University of Iowa College of Medicine, Iowa City

HOWARD F. ROOT: Associate in medicine, Harvard Medical School, Boston

HENRY A. SCHROEDER: Associate professor of medicine, Washington University School of Medicine, St. Louis

HENRY SCHWARTZ: Professor of surgery, Washington University School of Medicine, St. Louis

ALFRED UIHLEIN: Assistant professor of neurosurgery, University of Minnesota Graduate School, Rochester, Minnesota

## In-State Teachers

JOHN L. ARMBRUSTER: Associate professor of radiology, Marquette University School of Medicine

GARRETT A. COOPER: Assistant professor of dermatology and syphilology, University of Wisconsin Medical School

JAMES P. CONWAY: Assistant professor of pediatrics, Marquette University School of Medicine

HELEN A. DICKIE: Assistant professor of medicine, University of Wisconsin Medical School

JOSEPH W. GALE: Professor of surgery, University of Wisconsin Medical School

THOMAS V. GEPPERT: Head of Department of Pediatrics, Dean Clinic, Madison

F. J. HOFMEISTER: Assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine

MISCHA J. LUSTOK: Assistant clinical professor of medicine, Cardiovascular Section, Marquette University School of Medicine

JOHN D. STEELE: Assistant clinical professor of surgery, Marquette University School of Medicine

HERMAN W. WIRKA: Associate professor of surgery (orthopedic surgery), University of Wisconsin Medical School

# Programs—

■ Each program starts promptly at 2:00 p.m. Speakers are not in order listed, so plan to attend ENTIRE meeting. Following dinner a question and answer period will conclude the program.

## March

| March 16 | March 17 | March 18 |
|---|---|---|
| Monroe | Kenosha | Portage |

DIAGNOSIS AND TREATMENT OF VAGINITIS AND CANCER OF THE CERVIX: Edward D. Allen, M.D., Chicago

PROBLEMS OF GROWTH, INCLUDING ADOLESCENCE: Thomas V. Geppert, M.D., Madison ("Erythroblastosis" at Portage)

THE MANAGEMENT OF CARDIOVASCULAR PROBLEMS: Mischa J. Lustok, M.D., Milwaukee

THE EARLY MANAGEMENT OF THE ACUTE HEAD INJURY: Alfred Uihlein, M.D., Rochester, Minnesota

## April

| April 27 | April 28 | April 29 |
|---|---|---|
| Platteville | Oconomowoc | Manitowoc |

MATERNAL MORTALITY FINDINGS AND CONCLUSIONS IN RELATION TO MEDICAL PRACTICE IN WISCONSIN: F. J. Hofmeister, M.D., Milwaukee

INFANT AND CHILD NUTRITION: Robert L. Jackson, M.D., Iowa City

DIABETIC EMERGENCIES: Howard F. Root, M.D., Boston

FRACTURES OF THE ANKLE: Herman W. Wirka, M.D., Madison

■

## April

RELATED DISEASES OF THE CHEST

| April 13 | April 14 | April 15 |
|---|---|---|
| Eau Claire | Stevens Point | Appleton |

RADIOLOGIC ASPECTS OF DIFFERENTIAL DIAGNOSIS OF PULMONARY DISEASE: John L. Armbruster, M.D., Milwaukee

COMMON FUNGUS DISEASES OF THE CHEST: Helen A. Dickie, M.D., Madison

SELECTION OF PATIENTS WHO MIGHT BE BENEFITED BY SOME FORM OF CARDIAC SURGERY: Thomas J. Dry, M.D., Rochester, Minnesota

SUPPURATIVE DISEASES OF THE CHEST: John D. Steele, M.D., Milwaukee

■

## May

| May 25 | May 26 | May 27 |
|---|---|---|
| Chippewa Falls | Pinecrest (Iron River) | Rhinelander |

TREATMENT OF COMMON SKIN LESIONS: Garrett A. Cooper, M.D., Madison

ENDOCRINE THERAPY IN GYNECOLOGIC DISORDERS IN RELATION TO CANCER: Edwin J. DeCosta, M.D., Chicago

MODERN MANAGEMENT OF HYPERTENSION: Henry A. Schroeder, M.D., St. Louis

A REVIEW OF NEUROLOGICAL SURGERY: Henry Schwartz, M.D., St. Louis

FOR JUNE PROGRAM AND RESERVATION SLIP—TURN PAGE

## June

**Wednesday, June 16**

**Racine**

CURRENT THERAPY IN THE TREATMENT OF TOXEMIAS: Allan C. Barnes, M.D., Cleveland

DIAGNOSIS AND TREATMENT OF LIVER DISEASE: Richard B. Capps, M.D., Chicago

**Thursday, June 17**

**Elkhart Lake**

MEETING PROBLEMS OF PREMATURITY IN GENERAL PRACTICE: James P. Conway, M.D., Milwaukee

WHAT SURGERY HAS TO OFFER IN PULMONARY DISEASE: Joseph W. Gale, M.D., Madison

**Friday, June 18**

**Menominee, Michigan**

## SPECIAL FEATURES OF MEETING IN MENOMINEE, MICHIGAN

The Friday meeting on June 18 will form the afternoon program of the Upper Peninsula Medical Association two-day scientific session. The entire program will be as follows:

### Friday Morning

STROKES, DIFFERENTIAL DIAGNOSIS: Adolph Sahs, M.D., Iowa City

WHAT THE GENERAL PRACTITIONER CAN DO IN RELATION TO EMOTIONAL DISTURBANCES: John Schindler, M.D., Monroe, Wisconsin

### Friday Afternoon

(The program listed above as a part of the circuit will be presented from 2:00–5:00 p.m.)

### Friday Evening

Smörgasbord dinner and special entertainment. Dance after 9:00 p.m.

### Saturday Morning

HOW TO HANDLE DISABILITIES: E. A. Irvin, M.D., Detroit

DERMATOSES OF INTEREST TO THE GENERAL PRACTITIONER: E. Richard Harrell, M.D., Ann Arbor, Michigan

AN EVALUATION OF NEW DRUGS IN TREATMENT OF SELECTED DISEASES: Harry Beckman, M.D., Milwaukee

### Saturday Afternoon

Free time for golfing, yachting, and other forms of entertainment for both MDs and their wives.

### Saturday Evening

Banquet—Speech—Dance

(Registration for both days: $7.50 plus cost of dinners. No registration fee for wives, as only charge will be for the meals. Tickets for meals can be purchased at the time of registration.)

---

## Registration Blank

(Detach and Mail with Check, Payable to State Medical Society of Wisconsin. Mail to Box 1109, Madison, Wisconsin)

CHECK THE CLINICS YOU WILL ATTEND: $6.00 per clinic except for Menominee, Michigan. (If you will attend two-day session, the charge will be $7.50).

March 16: Monroe ____
March 17: Kenosha ____
March 18: Portage ____
April 13: Eau Claire ____
April 14: Stevens Point ____
April 15: Appleton ____
April 27: Platteville ____
April 28: Oconomowoc ____
April 29: Manitowoc ____
May 25: Chippewa Falls ____
May 26: Pinecrest ____
May 27: Rhinelander ____
June 16: Racine ____
June 17: Elkhart Lake ____
June 18: Menominee, Michigan ____

# . . . . THE PRESIDENT'S PAGE . . . .

THE President has given his long-awaited message to Congress on the state of the nation's health and it is, quite naturally, evoking a varied response. There can be no argument as to his objective because it is agreed upon by everyone who has any interest in the problem. This objective, briefly stated, is the distribution of a high-grade medical service to all who need it at a price they can afford to pay.

There are, as yet, no specific legislative proposals to implement his program, but it seems fairly certain that some form of federal fund to reinsure the risks taken by private companies such as WPS will be an integral part of such legislation. This is in line with the party's campaign promises to encourage private enterprise and, when viewed in that light, must merit the approval of all who subscribe to that doctrine. But it is by no means certain that government reinsurance, or in other words, government subsidy, will enable us to attain that desirable goal of wide distribution and wide coverage. Marketing methods to reach large numbers of small groups and individuals not now covered make a fertile field for research. Adjustment of some regulations which now prohibit payroll deduction in governmental groups might result in considerable expansion of coverage. These and many other aspects of the problem need exploration and evaluation by representatives from the fields of insurance, medicine, economics, politics, labor, etc. This brings me to the crux of what I have to say, viz.;

Governmental interest and participation in the nation's health is a sociological and political trend which has developed and grown to a point that leaves little room for doubt that it is here to stay. Whether we agree with it or not and whether we like it or not, we cannot possibly stop it. But by offering intelligent, forward-looking cooperation we should be able to help direct this trend into channels which will assist us all to attain our common objectives.

As I see it, then, the next move is up to organized medicine—to acknowledge and keep our attention focused on the similarity of our aims; to believe the President's oft-repeated statement that he is opposed to socialized medicine; and finally to come up with a positive, constructive program which will at long last remove us from the ranks of the chronic obstructionists.

And in closing may I say this: I regard the President's Page as a place where the President can "sound off" on his own ideas, as well as where he can report on Society business. Therefore, the phrase we often hear over the radio applies here, too: "The views you have just read are those of the writer, and the other officers of the Society do not necessarily agree or disagree."

H Kent Tenney M.D.

# The Wisconsin Press-Commentator

Excerpts from Editorial Opinions
Published in the Wisconsin Daily and Weekly Press

## Medicine and the Press

The American Medical Association is endeavoring to modernize its attitude respecting publicity. It seems to be the belief of many leaders in the profession that its code of ethics respecting publicity has been a bit too rigid.

Doctors are busy men. Perhaps they do not have much time to spend with representatives of the press. But they have long been bound by a code of ethics that may have prevented them from receiving the public recognition for their services to which they are legitimately entitled.

A certain change and modification can be made without bringing any undue advantage or benefit to quacks and mountebanks.—PORTAGE REGISTER-DEMOCRAT, Jan. 7, 1954.

## Achievements and Problems

The achievements of American medicine are outstanding . . . But . . . they are working intensively on some difficult problems which are yet to be solved . . .

Studies and experiments now under way are designed to find sound ways and means to meet the costs of health insurance in old age.

Another complex problem is that of chronic, or catastrophic, illness . . .

No one would expect such problems to be solved overnight. But it is important to realize that they are worked out within the framework of our free society without the use of compulsion, without subjecting the taxpayers to the staggering load that socialized medicine or any variant of it would involve, and without undermining the independence, rights and self-respect of doctor and patient—RIPON PRESS, Jan. 6, 1954.

## Government Reinsurance

Just what the President means by "limited government reinsurance service" on medical and hospital insurance plans will have to await his special message Jan. 18.

Public aid in meeting the burden of heavy illness costs is long overdue, but if Eisenhower is drafting a plan on a pattern set by the American Medical Association, it may turn out to be a "doctors' relief bill," rather than a help to persons who cannot or will not buy their own health insurance.—MADISON CAPITAL TIMES, Jan. 8, 1954.

## Information vs. Fee-Splitting

The January 16 *Saturday Evening Post* carries an article . . . which describes various ways in which fee-splitting surgeons and practitioners have been known to divide the fees paid by patients . . .

The key to public education against fee-splitting is intelligent questioning of each doctor about his fee and how it can be paid, for fee-splitting depends on the ignorance of the patient that a deal has been made between the referring physician and the surgeon. As a matter of self-protection, the patient should know who gets how much and for what.—WAUKESHA FREEMAN, Jan. 13, 1954.

## Health Councils Needed

The Board of Health efforts to promote formation of county health councils were severely criticized last year by some newspapers and legislators . . .

In Illinois . . . health improvement associations have been formed in 69 of the 102 counties. The state medical society and the Illinois Agricultural association, to which a big majority of Illinois farmers belong, did much in encouraging the formation of these county associations . . .

What's needed in Wisconsin, apparently, is some more push from the farm organizations and the state and county medical associations, such as was applied in Illinois.—MILWAUKEE JOURNAL, Jan. 12, 1954.

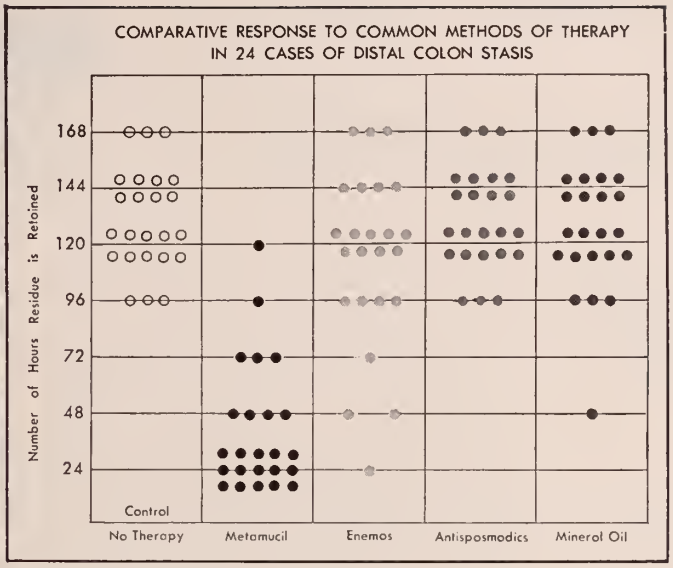
## Community Medicine

Richland, Wash., has cut its death rate of 2.2 a thousand, just one-half the national average of 4.4.

Founded ten years ago as an atomic plant site, Richland is now a city of 24,000 people. Its health is ascribed to an integrated community program, including public health, industrial medicine, adequate hospital facilities, general patient care and voluntary health insurance.

The amazing results have shown that initiative on the local level can be effective in providing good health and good medical care without the regimentation of a national health program supported by higher and higher taxes.—BEAVER DAM CITIZEN, Jan. 6, 1954.

Distal Colon Stasis




# Management of Distal Colon Stasis with Metamucil®

The "irritable colon" resulting in distal colon stasis is a hard-to-manage by-product of many abdominal or stress conditions.

Roentgen evaluation of the commonly used methods to combat colonic stasis has shown the value of Metamucil because of its lack of irritation and its high degree of effectiveness* in this most prevalent type of stasis.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It produces smooth fecal bulk necessary to incite the normal peristaltic reflexes, without causing irritation, straining, impaction or interference with the digestion or absorption of vitamins.

The average adult dose is one teaspoonful of Metamucil powder in a glass of cool water, milk or juice, followed by an additional glass of fluid if indicated. This amount of fluid is essential for the production of "smoothage."

It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE *Research in the Service of Medicine*

*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis. Rev. Gastroenterol. *19*:154 (Feb.) 1952.

# COMMITTEE *Concentrates*

**COMMITTEE ON CANCER**
**NOVEMBER 21**
**MADISON**

MDs Present: A. R. Curreri, W. S. Bump, Roy Larsen, G. I. Uhrich, Lucille Radke, and P. B. Blanchard.

The meeting consisted entirely of matters concerning the program of the Wisconsin Division of the American Cancer Society. Funds were voted for support of the Annual Meeting and the circuit teaching programs of the State Medical Society . . . A favorable report on the MD–Dentist programs held in Eau Claire, Stevens Point, and Appleton prompted the Committee to recommend further expansion of these programs, with the State Board of Health as a joint sponsor. The Committee reviewed standards for the training of technicians in exfoliative cytology through use of funds provided by the Wisconsin Division for such purposes. The proposed distribution of the publication *CA* to members of The State Medical Society outside of Milwaukee County, through funds provided by the Wisconsin Division, was discussed and referred to the Coordinating Committee on Cancer for further study.

**COUNCIL ON SCIENTIFIC WORK**
**NOVEMBER 21**
**MILWAUKEE**

MDs Present: J. W. Gale, P. A. Midelfart, S. A. Morton, M. G. Rice, L. G. Kindschi, R. S. Baldwin.

The Council elected J. W. Gale as chairman for 1954 and assigned the following duties to members: S. A. Morton to represent the Council and serve as chairman of the Coordinating Committee on Postgraduate Education in planning all related scientific programs in 1955; P. A. Midelfart, general chairman, 1954 Annual Meeting; M. G. Rice, chairman of scientific exhibits, 1954 Annual Meeting; L. G. Kindschi, chairman of demonstrations, 1954 Annual Meeting. The major portion of the meeting was devoted to preliminary determination of program content for the 1954 Annual Meeting. The Council also approved further development of teaching programs with the Wisconsin Division of the American Cancer Society and the State Board of Health in oral cancer and other topics related to carcinoma, and cooperation with the Division on Mental Hygiene in the development of special programs on mental deficiency at Northern and Southern Colonies.

**COORDINATING COMMITTEE ON CANCER**
**DECEMBER 8**
**MADISON**

MDs Present: R. P. Welbourne, A. R. Curreri, W. D. Stovall, R. J. Krill, Arthur Van Duser, and Milton Feig.

The creation of this special committee was suggested by the Committee on Cancer as a means of coordinating the programs of the two Wisconsin divisions of the American Cancer Society and the related work of the State Board of Health. As a service to State Medical Society members outside of Milwaukee County, it was agreed to have the Wisconsin Division supply each with a year's subscription to the publication *CA*, after which a determination would be made if physicians receiving *CA* as well as the *Cancer Bulletin* supplied by the State Board of Health wish to receive both, or have preference for one over the other. As a means of stimulating professional interest in cancer programs and special teaching films, a survey of hospital staff practices will be conducted, with special attention directed to services available through the two divisions of the American Cancer Society. Consideration was given the proposed nation-wide study of lung cancer, with a recommendation made that if the two divisions agree to sponsor such a program, the details and procedures should be worked out through joint conference between the professional education committees serving the separate divisions.

**COMMISSION ON PREPAID PLANS**
**DECEMBER 12–13**
**MADISON**

MDs Present: E. M. Dessloch (chairman), Robert Krohn, N. A. Hill, J. T. Sprague, H. E. Kasten, R. E. Garrison, K. H. Doege, Milton Finn, C. G. Reznichek, J. S. Supernaw, H. A. Aageson, R. M. Moore, P. B. Mason, Richard Foregger, G. W. Carlson, W. T. Casper, H. Kent Tenney, A. J. McCarey, E. L. Bernhart, R. C. Parkin.

Re-emphasized concept of "bitter and sweet" in connection with inclusion of "usual" pre- and postoperative care in surgical benefit . . . no definite measure of a "usual" period can be stated . . . claim for benefits for "unusual" services must originate from the physician concerned. Closed reduction of a fracture preparatory to an open reduction cannot be considered a remedial effort in itself but part of the total procedure . . . only benefit for open reduction is allowable. Services of physicians and surgeons in connection with dental surgery approved in certain instances. First draft of a catastrophic illness service endorsement to group contracts approved, incorporating principles earlier reported. Special committee appointed to review interstaff agency contract negotiations and to proceed with Blue Cross policy level. Discussed problems associated with the national Blue Shield insurance company, Medical Indemnity of America, Inc., with Doctor Bernhart and Mr. J. O. Kelley, members of its board, and the special meeting of plans in January . . . approved circulation of WPS staff analysis of issues involved to Blue Shield plans and state societies.

**COMMITTEE ON CIVIL DEFENSE**
**JANUARY 14**
**MADISON**

MDs Present: M. J. Musser (chairman), E. P. Ludwig, J. S. Wier, E. A. Bachhuber, C. K. Kincaid, J. W. Wishart, A. L. Van Duser.

It was reported that nearly 80 of the 100 mobile medical teams in the State Civil Defense program have selected key personnel. All medical supplies and equipment for each team are now stored at Camp Williams. The Committee recommended that they be packaged into units for distribution to each team. General Olson proposed a timetable of planning for training of teams. All personnel are to be named for each team, no more than one training session per year is required, and the entire unit is to be held on a stand-by basis. The Committee agreed that Civil Defense is a continuing necessity for all county medical societies.

**GRIEVANCE COMMITTEE**
**DECEMBER 20**
**MADISON**

MDs Present: R. E. Fitzgerald (chairman), C. E. Zellmer, F. A. Nause, H. W. Wirka, C. D. Neidhold, C. B. Hatleberg, J. L. Moffett, H. Kent Tenney.

**RELATED ACTIVITIES**

Tentative plans have been made for several conferences between dentists and physicians in areas of oral cancer, cancer of the breast, cancer of the lower bowel, and cancer of the skin. While all programs will not be completed this year, the proposed sites are Sheboygan; Oshkosh or Fond du Lac; Janesville; La Crosse; Green Bay; Racine; and possibly Superior. While primary emphasis will be on oral cancer, topics related to cancer of the breast, cervix, thoracic cavity, bowel, and skin will all be covered during the course of the various conferences . . . hearing loss associated with industrial exposure has caused the creation of a special subcommittee of the Division on Hearing and Vision, which is busy preparing a suggested guide for the establishment of hearing conservation programs. Members of this committee are Drs. T. L. Tolan, chairman; Meyer S. Fox; Paul Whitaker; L. C. Gardner; Charles Taborsky; and George Nadeau, Jr. As a corollary activity, this committee is working with the Extension Division of the University of Wisconsin on the development of a special institute in Madison this summer for the training of persons in industry who will conduct the initial screening programs as the basis of compiling records on hearing measurements of employees . . . The State Medical Society has been working with the State Health Officer, the Department of Public Instruction, and the National Foundation on the state's participation in the vaccination of second grade children in selected areas as a test of the Salk Vaccine. By now the selected areas have been announced and local arrangements have been made for further development of the program, which will be launched in Wisconsin this coming spring . . . A series of conferences on "Medical Aspects of Mental Deficiency" are being planned in cooperation with the Division on Mental Hygiene of the Department of Public Welfare. Plans call for meetings, with use of patients, at Union Grove and Northern Colony this spring and early fall. All doctors interested are invited to participate.

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Treatment of the "problem drinker" is more than a sobering-up process; it is a rehabilitative procedure which must be tailored to the needs of the individual.

Years of intensive research and specialized clinical experience enable us to follow through in all phases of modern restorative treatment—gradual withdrawal, physical rehabilitation, re-orientation and re-education.

You may refer female as well as male patients—we are also equipped to care for narcotic or barbiturate addiction. Moderate rates; treatment period sometimes shortened to just two weeks.

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RICAN MEDICAL ASSOCIATION news notes

FEBRUARY 1954

AMA news written especially for use in state medical journals

## Regional Meeting on Veterans Care

More regional conferences on veterans medical care will be held during 1954 under the sponsorship of the AMA's Council on Medical Service through its Committee on Federal Medical Services. These meetings have a fourfold purpose: (1) To develop a working liaison with state society committees concerned with veterans' problems; (2) To acquaint an increasing number of physicians with AMA policy and the facts regarding veterans care; (3) To learn the local situation regarding this policy in various states; and (4) To discuss ways of carrying out the instructions of the House of Delegates, which adopted a firm stand on veterans medical care at its meeting last June.

The present schedule calls for meetings early in the year: February 19, Denver; February 21, Portland, Oregon; February 27, Omaha; and in March, Boston and either Chicago or Indianapolis. Four similar conferences were held last year in Dallas, Atlanta, New York, and Washington, D. C.

## '54 Radio and TV Plans Announced

America's physicians will be "on the airways" more than ever during the new year as the AMA's Bureau of Health Education announces plans for new radio and television programs. In response to the trend of audiences listening to local radio shows, emphasis will be placed on locally originated programs both in radio and television.

Present television plans call for a 30-minute film relating to some aspect of medical care to be produced jointly by the Bureau and the Department of Public Relations. This film probably will be available about the time of the AMA's June meeting. In addition, several new sequences will be developed in the "What To Do" series—the five-minute TV films which star the popular woman's commentator, Nancy Craig, explaining safe procedures to follow in home emergencies.

Inaugurating a new service for state and county medical societies, the Bureau also is planning the preparation of "script-clip packages" for television. These packets will contain outline scripts which can be narrated by local doctors while film clips illustrating the topic are shown on the TV screen.

Regarding radio plans, the Bureau will concentrate on new electrical transcriptions during 1954. These will be released approximately at the end of April, June, and October. The first will be devoted to science and superstition, and other topics will be announced later.

## AMA Studies Physician Attitudes On Insurance

While there is no doubt that most physicians favor the many forms of voluntary health insurance now in existence over any compulsory tax system, no attempt has been made to analyze attitudes of physicians regarding certain aspects of the voluntary type of protection. The AMA's Council on Medical Service, through its Committee on Prepayment Medical and Hospital Service, currently is sponsoring a survey of these underlying doctor attitudes.

Since voluntary insurance programs are insuring an increasing number of persons each year, the attitudes of physicians—as they are the ones who render professional treatment to policyholders—are important factors to consider in the future plans of insurance programs.

Among other things, the AMA survey is designed to bring to light certain physician attitudes regarding service benefits, the extent to which the principle of coinsurance should apply, the adequacy of benefits (fee schedules), the extent to which insurance may influence the cost of health care, and so forth.

Although the Council on Medical Service is sponsoring this study, the questionnaire itself was compiled after consultations with the Bureau of Medical Economic Research, representatives from Blue Shield, and other organizations.

## 4-H Winners Get "Today's Health"

Inaugurating a new project in its rural health education program, the State Medical Society of Wisconsin decided in November to give one-year gift subscriptions to "Today's Health" magazine to all 4–H Club achievement winners throughout the state. In announcing the gift, the Society urged each of the 40 winners to circulate the magazine to other club members. For many years the Society has given engraved certificates to these winners but this time felt that a subscription was a much more practical gift. Other medical societies might well follow Wisconsin's example.

## AMA Exhibit in Nation's Capital

By special invitation of the museum, the American Medical Association will display its exhibit, "The Organs of the Human Body," at the Smithsonian Institute in Washington, D. C. during 1954. After this year, this exhibit will be available for showings in other museums throughout the country.

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# Society Proceedings

## Ashland–Bayfield–Iron

*Dr. Joseph Majewski*, head of the Department of Obstetrics, Milwaukee County Hospital, was the guest speaker at the dinner meeting of the Ashland–Bayfield–Iron Counties Medical Society held on December 9. The meeting was at the Menard Hotel in Ashland.

## Brown–Kewaunee–Door

Meeting at the Green Bay Elks Club on December 10, members of the Brown–Kewaunee–Door Counties Medical Society chose their officers for 1954. *Dr. G. B. Merline* of De Pere was elected president, and *Dr. J. W. Nellen* of Green Bay was chosen president-elect. Vice-president is *Dr. L. C. Miller*, Green Bay; and *Dr. G. M. Shinners*, also of Green Bay, was re-elected secretary. Doctor Miller and *Dr. R. M. Walkirch*, De Pere, are to be the delegates to the State Society Annual Meeting, with *Drs. P. F. Dockry* and *S. L. Griggs*, both of Green Bay, as alternates.

## Dodge

The regular meeting of the Dodge County Medical Society was held at St. Joseph's Hospital, Beaver Dam, on November 19. *Dr. H. G. Bayley*, Beaver Dam, outlined the progress of the county Civilian Defense Program from the medical standpoint.

Members of the society had their annual Christmas dinner meeting at the Beaver Dam Elks Club on December 12.

## Green Lake–Waushara

Officers elected by the Green Lake–Waushara Counties Medical Society at its December 10 meeting at the Hotel Whiting in Berlin are:

President—*Dr. Russell Pelton*, Markesan
Vice-President—*Dr. D. J. Sievers*, Berlin
Secretary-Treasurer—*Dr. L. S. Shemanski*, Wautoma
Delegate—*Dr. H. C. Koch*, Berlin
Alternate Delegate—*Dr. Roy Hong*, Wild Rose

The discussion at the meeting was mainly about the operation of the Red Cross Civilian Blood Donor Service and the feasibility of initiating this service at the Berlin Memorial Hospital.

Following the business meeting, *Dr. A. J. Wiesender*, Berlin, showed slides and discussed his recent trip to Greece and other European countries.

## Kenosha

*Dr. Richard M. Block* was elected president of the Kenosha County Medical Society at its meeting held on December 10 at the Kenosha Elks Club. *Dr. Lief Lokvam* was named president-elect, and *Dr. Helen Binnie* will continue as secretary. *Dr. D. H. Goldstein* and Doctor Lokvam were re-elected as delegate and alternate delegate from the society. All of the officers are from Kenosha.

## Pierce–St. Croix

Dr. Donald G. Lannin, orthopedic surgeon from St. Paul, demonstrated the most recent developments in the management of elbow fractures in children at the November 17 meeting of the Pierce–St. Croix Counties Medical Society held in Hudson. Immunization and pre-school examination programs were also discussed at the meeting.

A symposium on "Low Back Syndrome" was presented at the meeting of the society on December 15 by two St. Paul physicians, Dr. D. L. McCain, orthopedic surgeon, and Dr. Leo Nash, radiologist. Doctor Nash presented x-ray examples, and Doctor McCain discussed the clinical diagnosis and management of the conditions shown.

## Polk

*Dr. F. B. Riegel*, St. Croix Falls, was elected president of the Polk County Medical Society at its meeting held at the Osceola High School on October 22. Other officers elected were *Dr. M. G. Marra*, Amery, vice-president, and *Dr. L. J. Weller*, Osceola, secretary-treasurer.

"E. N. T. Problems of the General Practitioner" was the subject of the talk presented by the guest speaker, Dr. Lawrence Boies of Minneapolis. *Dr. L. O. Simenstad* of Osceola presented the delegate's report from the State Medical Society Annual Meeting.

## Price–Taylor

Meeting at the Leahy Clinic in Park Falls on November 21, members of the Price–Taylor Counties Medical Society heard a discussion about backache by *Dr. R. E. Burns* of the University of Wisconsin Medical School. *Drs. J. H. Leahy, J. L. Murphy*, and *W. L. McLane* of the local society also participated in the discussion.

Members discussed the diabetes detection drive at their business meeting.

## Richland

"Cardiac Arrhythmias" was the subject discussed by *Dr. H. H. Shapiro* at the November 5 meeting of the Richland County Medical Society held in Richland Center. Doctor Shapiro is in the Cardiology Department at Wisconsin General Hospital, Madison.

### Waukesha

Oconomowoc physician, *Dr. Peter Theobald*, was elected president of the Waukesha County Medical Society at its meeting held December 2 at Rogers Memorial Sanitarium. *Dr. Hyman Gantz*, Waukesha, was named vice-president; and *Dr. Frederick A. Thompson*, also of Waukesha, is the new secretary-treasurer.

### Winnebago

*Dr. L. W. Paul*, professor of radiology at the University of Wisconsin, spoke at the November 5 meeting of the Winnebago County Medical Society held at the Valley Inn in Neenah. "Roentgen Aspects of Chronic Arthritis" was the subject of his talk.

On December 3 members of the society elected 1954 officers at their meeting at the Town Grill in Oshkosh. *Dr. B. S. Greenwood*, Oshkosh, is the new president, and *Dr. John Conway*, Menasha, the president-elect. *Dr. G. B. Hildebrand*, Menasha, was re-elected secretary-treasurer; and *Dr. R. H. Bitter*, Oshkosh, and *Dr. George Schwei*, Neenah, were elected delegates, with *Dr. David Regan*, Neenah, and *Dr. W. V. Hahn*, Oshkosh, as alternates.

A movie on the frog test for pregnancy was shown, and delegates to the Annual Meeting of the State Medical Society presented their reports.

# News Items and Personals

### Dr. McCabe Stationed at Brooke

*Captain Lloyd B. McCabe*, formerly of Fond du Lac, has been assigned to the Department of Medicine at Brooke Army Hospital, Fort Sam Houston, Texas. Captain McCabe recently completed a year's tour of duty with the 7th Medical Battalion in Korea. A graduate of the St. Louis University School of Medicine, he formerly was in private practice in Fond du Lac.

### Dr. Hoff Joins Staff of Midelfart Clinic

Dr. Donald E. Hoff has joined the department of internal medicine at the Midelfart Clinic, Eau Claire. The doctor is a graduate of the University of Kansas School of Medicine and took postgraduate work in roentgenology and internal medicine at the Cleveland Clinic in Ohio. He completed his training at University Hospitals, Madison, during the past year.

### Watertown Physician Retires

*Dr. Otto F. Dierker*, Watertown, recently retired from practice after over 48 years as a physician specializing in eye, ear, nose, and throat diseases. A 1905 graduate of the University of Louisville, the doctor first practiced in Sylvan Grove, Kansas, where he remained for 15 years. He then decided to take postgraduate work and after completing it moved to Nebraska, where he practiced for three years. He came to Watertown in 1924. Doctor Dierker was one of the organizers and first president of St. Mary's Hospital staff, a position he held for nine years.

### Cashton Gets New Doctor

Dr. David E. Vig, who had previously practiced in Viroqua, has moved to a new location in Cashton. Doctor Vig is a graduate of the University of Wisconsin Medical School and served his internship at the Medical College of Virginia in Richmond, Virginia. While in Viroqua he was associated in practice with *Drs. Lars Gulbrandsen, Edward N. Vig*, and *De Verne Vig*.

### Dr. Heraty Has New Associate

Early in December *Dr. J. R. Richter*, Chaseburg, became associated with *Dr. J. E. Heraty*, La Crosse, in the general practice of medicine. Doctor Richter has practiced in Chaseburg for the past 12 years and plans to keep his office open there for morning and evening office hours.

### Marinette General Hospital Elects Officer

At its December 10 meeting, the medical staff of Marinette General Hospital elected *Dr. R. J. Rogers* as its president for 1954. Doctor Rogers, who lives in Oconto, serves as consulting pathologist to a number of hospitals in the immediate area.

### Dr. Dangle Replaces Dr. Miale at Marshfield

Late in October *Dr. Harland C. Dangle* replaced *Dr. John B. Miale* as pathologist on the staffs of the St. Joseph's Hospital and the Marshfield Clinic. Doctor Miale resigned last summer to accept a position as professor of clinical pathology at Miami (Fla.) Medical School.

A 1944 graduate of Marquette University School of Medicine, Doctor Dangle interned at St. Agnes Hospital, Fond du Lac, and also at a Chicago hospital. He then served two years with the Army Medical Corps before beginning his residency in pathology at the Veterans Hospital in Wood. From 1951 to 1952 he was assistant pathologist at Wood, and from 1952 until he assumed his duties at Marshfield he was pathologist at Waukesha Memorial Hospital. During his residency at Wood, he also served as a clinical instructor in pathology at Marquette.

### Appleton Physicians Address Rotarians

*Dr. J. P. Skibba*, Appleton urologist, was the guest speaker at the October 19 meeting of the New London Rotary Club. He illustrated his talk with

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a number of slides. Another Appleton physician, *Dr. Carl D. Neidhold*, addressed the Rotarians at their next meeting.

### Dr. Klepfer Accepts New Position

*Dr. J. F. Klepfer*, Waupun, resigned as superintendent of the Central State Hospital on November 20. He has accepted the position of superintendent of the Richmond State Hospital in Richmond, Ind. Acting superintendents at Central State Hospital are Dr. Rene Warmington, in charge of psychiatric work, and M. A. Skaff, who handles administrative affairs.

### Dr. Low Receives Fellowship

*Dr. N. L. Low*, Racine, has accepted a one-year fellowship in epilepsy at the Illinois Neuropsychiatric Institute for 1954. A graduate of the Medical College of the State of South Carolina, Doctor Low interned at St. Mary's Hospital, Racine. He served in the armed forces from September 1943 to May of 1946.

## THIRD AND TWELFTH DISTRICTS NEWS

### Dr. Angevine Attends National Meetings

*Dr. D. M. Angevine*, Madison, participated in the National Conference on Research and Education in Rheumatic Diseases which was held at the National Institute of Health, Bethesda, Md., on November 19. On the following day he attended a meeting of the executive committee of the American Rheumatism Association. Doctor Angevine is chairman of the Department of Pathology at the University of Wisconsin Medical School.

### Madison General Elects Officers

*Dr. C. O. Vingom* has been elected chief of staff of the Madison General Hospital medical staff for 1954. *Dr. H. M. Carter* was elected vice-chief; *Dr. E. J. Nordby* was named secretary-treasurer; and *Dr. Louis Fauerbach* was elected trustee to the Dane County Medical Society. Section chiefs who will serve with the officers include *Dr. J. S. Supernaw*, surgery; *Dr. A. B. Weinstein*, medicine; *Dr. T. J. Nereim*, general practice; *Dr. C. S. Harper*, obstetrics and gynecology; and *Dr. A. M. Iams*, pediatrics.

At the November meeting of the hospital staff, Doctor Iams was the speaker. He chose "Abdominal Pain in Children" as his topic.

### Dr. Campbell Appointed Director

*Dr. Ralph E. Campbell*, professor of obstetrics and gynecology at the University of Wisconsin Medical School, has been appointed a director of the Foundation of the American Association of Obstetricians and Gynecologists. He also has been

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## Dr. Reinardy Is New Head of Hospital Staff

At the annual meeting of the Janesville Mercy Hospital Staff, *Dr. E. W. Reinardy* of the Munn–Koch Clinic was elected president. He succeeds *Dr. C. R. Gilbertsen.* Other officers elected include *Dr. Milton J. Donkle*, vice president; *Dr. John F. Holmes*, Milton Junction, secretary-treasurer; and *Drs. Jack Schroeder, Herbert Snodgrass* and *C. R. Gilbertsen*, executive board members.

Except where otherwise noted, all of the officers are from Janesville.

## Dr. Hobbins Promoted

*Dr. William B. Hobbins*, Madison surgeon who has been serving with the surgical service at Camp Carson Army Hospital, Colorado Springs, Colo., recently was promoted to the rank of captain. During the past fall, Doctor Hobbins was made a fellow in the American College of Surgeons and was elected a fellow in the International College of Surgeons. He plans to return to Madison on completion of his tour of duty.

## Rock

Discussing "Pernicious Anemia and a New Test for Intrinsic Factor Activity," Dr. Robert F. Schilling, Assistant Professor of Medicine at the University of Wisconsin, was the guest speaker at the meeting of the Rock County Medical Society held on November 24.

About 45 members attended the meeting, which was held at the Monterey Hotel in Janesville.

## Sauk

Walter Argow, Executive Director of the Wisconsin Association for Mental Health, was the guest speaker at the meeting of the Sauk County Medical Society held at the Warren Hotel in Baraboo on December 9.

New officers elected at this meeting are: president, *Dr. O. J. Pawlisch*, Reedsburg; vice-president, *Dr. B. E. McGonigle*, Baraboo; secretary-treasurer, *Dr. J. J. Rouse*, Reedsburg; delegate, *Dr. J. F. Moon*, Baraboo; and alternate delegate, Doctor Rouse.

## Milwaukee Physician Elected to Editorial Board

*Dr. Michael W. Shutkin*, gastroenterologist from Milwaukee, has recently been elected to the Editorial Board of the *American Journal of Gastroenterology.* Doctor Shutkin is a member of the faculty at Marquette University School of Medicine.

## Dr. Quick Receives Award

A. J. QUICK, M. D.

*Dr. Armand J. Quick*, professor of biochemistry at Marquette University School of Medicine, has been named one of the 10 recipients of the 1954 Modern Medicine Award by the medical journal of that name. Doctor Quick was honored for devising simple tests for hemorrhagic diseases and for work on the physiology of the control of bleeding.

The editorial board of *Modern Medicine* selects the 10 winners from nominations submitted by readers and the deans of medical schools.

## Epilepsy Is Subject of Two Talks

*Dr. Edward D. Schwade*, Milwaukee, addressed the November 12 conference of the Governor's Committee on Employment of the Physically Handicapped. A faculty member of Marquette University, the doctor spoke on "Employment Problems of the Epileptic."

Again speaking on the problems of the epileptic, Doctor Schwade was the guest speaker at a December 10 meeting in Madison which was sponsored by the Wisconsin Epilepsy League.

## Wisconsin Academy of General Practice Milwaukee Chapter

At the annual meeting of the Milwaukee Chapter of the Wisconsin Academy of General Practice held on December 2 at the Athletic Club, *Dr. Saul E. Biller* assumed the presidency for 1954. He succeeded *Dr. John A. Enright*. Officers elected to serve with Doctor Biller include *Dr. J. S. Devitt*, president-elect; *Dr. Ralph W. Garens*, secretary; and *Dr. Roland H. Frederick*, treasurer.

## Milwaukee

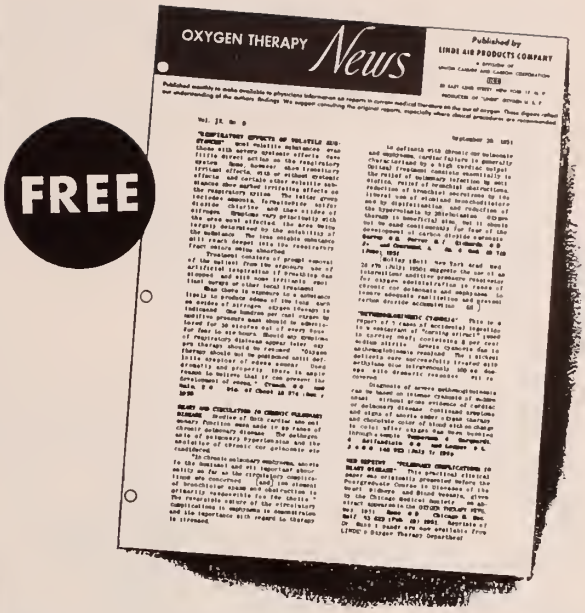
*Dr. J. G. Garland*, Milwaukee, took office as president of the Medical Society of Milwaukee County at the annual meeting of the group held at the Milwaukee Athletic Club on December 10. *Dr. D. V. Elconin* is the new president-elect, and *Dr. Donald M. Willson* was elected secretary of the society.

Speaker at the meeting was Dr. L. Howard Schriver, Cincinnati, Ohio.

## MARRIAGES

*Dr. Wayne M. Rounds*, Madison, to Miss Joan Grace Zuege, November 13.

*Dr. DeVerne W. Vig*, Viroqua, to Betty Jeanette Brewster, Weyauwega, December 19.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J. P. Magner, 114 West Davenport Street, Rhinelander.

R. F. Gosin, 207 East Walnut Street, Green Bay.

W. J. Smiles, 522 West Second Street, Ashland.

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R. G. Welsch, 723 58th Street, Kenosha.

D. M. Rowe, Kohler Clinic, Kohler.

J. H. Russell, Sheboygan Clinic, Sheboygan.

H. A. Ziel, Jr., Sheboygan Clinic, Sheboygan.

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H. R. Wood, 918 Huron Avenue, Sheboygan.

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C. W. Crawford, 110 East Main Street, Madison.

J. W. Cortner, 1323 Randall Court, Madison.

W. L. Bergwall, Denmark.

G. H. Reddick, Wabeno.

Lewis Turner III, 2604 Roosevelt Road, Kenosha.

L. W. Smith, 1408 Washington Avenue, Racine.

C. E. Quandt, 1108 Main Street, Jefferson.

A. J. Jacobsen, 314 Sixth Street, Racine.

A. P. Crosley, Jr., 2500 Overlook Terrace, Madison.

L. R. Prouty, 2 West Gorham Street, Madison.

C. L. Leslie, 161 West Wisconsin Avenue, Milwaukee.

C. H. Altshuler, 500 West Chambers Street, Milwaukee.

J. W. Knauf, Neopit.

### Changes of Address

T. J. Foley,* Oceanside, California, to 610 Honey Creek, Milwaukee.

J. L. Keating, Milwaukee, to Veterans Administration, Temple, Texas.

Louis Kagen,* Milwaukee, to 110 California, North Chicago, Illinois.

O. H. Stokke,* Chanute Air Force Base, Illinois, to 1348 North 44th Street, Milwaukee.

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1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. *53*:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. *74*:261 (June) 1950.
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6. King, E. Q., et al.: J. A. M. A. *143*:1 (May 6) 1950.


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H. W. Harris,* La Crosse, to 771 Havana Street, Aurora, Colorado.

J. E. Nilles,* Two Rivers, to MC01934150, Medical Company 279 Infantry, A.P.O. 86, c/o Postmaster, San Francisco, California.

J. A. Larkey, Milwaukee, to 4329 Spruce Street, Apartment 4, Philadelphia, Pennsylvania.

Royal Rotter,* Madison, to U. S. Army Hospital, Fort Lawton, Seattle, Washington.

D. S. Arvold,* Shawano, to 2437D Air Force Reserve Combat Training Center, 6081 North 43rd Street, Milwaukee.

J. G. Taylor, Milwaukee, to 4379 Ingraham Highway, Miami 33, Florida.

C. R. Olson, West Allis, to 161 West Wisconsin Avenue, Milwaukee.

P. E. Hanlon, Camp Gordon, Georgia, to 11 Stonefield Road, Glen Rock, New Jersey.

W. G. Gillies, Hazel Green, to 911 Third Street, Galena, Illinois.

P. L. Eisele, Springfield, Missouri, to Veterans Hospital, Waukesha.

K. L. Haman, Iola, to Waupaca.

W. D. Hamlin, Mineral Point, to Strong Bank Building, Dodgeville.

Yoshio Handa, Plain, to Veterans Administration Hospital, Hines, Illinois.

J. E. Koepsell, Harvard, Illinois, to 611 Roland Avenue, Rockford, Illinois.

F. S. Jones, Madison, to 2222 Fourth Avenue, Big Stone Gap, Virginia.

D. B. Becker, Jr., Fort Atkinson, to 130 Main Street, Oshkosh.

C. P. Giesen, Wauwatosa, to 1011 North Eighth Street, Sheboygan.

E. J. Hohler, San Antonio, Texas, to 251 High Street, Mineral Point.

A. E. Kuehn,* San Antonio, Texas, to Brooke Army Hospital, Annex IV, Fort Sam Houston, Texas.

J. F. Hildebrand, Sheboygan, to Department of Dermatology, Henry Ford Hospital, Detroit, Michigan.

M. A. Cornwall,* Hudson, to Second Field Hospital, A.P.O. 108, c/o Postmaster, New York, New York.

L. A. Van Ells, Wild Rose, to 1401 Douglas Avenue, Racine.

A. E. Leiser,* Greenville, South Carolina, to Cleveland Clinic, Cleveland, Ohio.

O. W. Rowlands, Dayton, Ohio, to 720 North Jefferson Street, Milwaukee.

N. L. Low, Racine, to E.E.G. Department, 912 South Wood Street, Chicago 12, Illinois.

W. M. Pfeifer, Milwaukee, to Pondville Hospital, Box 111, Walpole, Massachusetts.

J. P. Koehler, Milwaukee, to 5609 Gulfport Boulevard, St. Petersburg, Florida.

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* Military service.

V. E. McNeilus, West Salem, to 305 South Wilbur Avenue, Sayre, Pennsylvania.

W. P. Crowley, Jr., Madison, to 813 First Street, N. W., Rochester, Minnesota.

Howard Mauthe, Ripon, to 252 Sheboygan Street, Fond du Lac. (correction of error)

## DEATHS

**Dr. Ellis F. Swarthout**, formerly from Kenosha, died October 10 at Jensen's Beach, Florida, after an extended illness. He was 75 at the time of his death.

Born in 1878, he was graduated from the University of Illinois Medical School in 1903. Before moving to Florida in 1940, Doctor Swarthout was a member of the Kenosha County Medical Society, the State Medical Society, and the American Medical Association.

**Dr. James J. Scott**, 74, of Durand died on October 12 after a long illness. He was born on October 3, 1879, in Green County, Pennsylvania.

After graduating from high school, he instructed in rural schools for three years. He then attended Valparaiso College at Valparaiso, Indiana, and received his medical degree in 1906 from the American College of Medicine and Surgery, Chicago, now incorporated with Loyola University. From 1906 to 1909, Doctor Scott practiced at Weston. Leaving Weston, he moved to Eau Galle, where he practiced until 1922. He then moved to Durand, remaining there until his death.

Surviving him are his widow, Rose; two sons, Arthur of Rock Falls, and Robert of Durand; a daughter, Mrs. John (Dorothy) Pattison of Durand; eight grandchildren; two brothers, one in Pennsylvania and the other in Bryan, Ohio; and a sister in West Virginia.

**Dr. Robert A. Mullen**, a former member of the Burlington Memorial Hospital staff, died on November 5 at his home in Tampa, Florida, at the age of 53.

Doctor Mullen was born in La Crosse on June 4, 1900, and had practiced in Burlington and East Troy for 15 years before moving to Florida three years ago. He was a graduate of the Marquette University School of Medicine and a member of the Walworth County Medical Society, the State Medical Society, and the American Medical Association. During World War II, he served as a captain in the medical corps.

He is survived by his widow, Mary; three sons, Robert, Thomas, and Michael; one daughter, Kathleen; three brothers, James of La Grange, Illinois, Donald of Wichita, Kansas, and Thomas of La Crosse; three sisters, Mrs. Mary Devitt of West Allis, Mrs. Helen Moran of River Forest, Illinois, and Mrs. Nina March of Slinger, Minnesota.

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**Dr. Alfred E. Belitz**, Pepin physician for 35 years, died on November 9 at the age of 87.

Born at Kiel, Wisconsin, July 2, 1866, Doctor Belitz was graduated from the College of Physicians and Surgeons, Chicago, in 1895. After practicing for several years in Chicago, he went to Gunnison, Utah, and later to Seattle, Washington, and San Jose, California, before returning to Waumandee, Wisconsin. Later he practiced for eight years in Milwaukee and also taught at the College of Physicians and Surgeons, which is now a part of Marquette University. He also practiced at Cochrane for a time. In 1918 he moved to Pepin and served that community for 35 years. Only the last three years were spent in semi-retirement.

Doctor Belitz was granted a life membership in the State Medical Society in 1946, and since 1948 was a member of the Fifty-Year Club of the State Society. He was a member of the Eau Claire–Dunn–Pepin Counties Medical Society, the State Medical Society, and the American Medical Association. Doctor Belitz had served as village health officer of Pepin for many years.

In 1950, the citizens of Pepin honored Doctor Belitz at an "Open House" tea and banquet sponsored by the Pepin Commercial Club. His many fellow associates at this time paid tribute to the doctor, and presented him with a plaque containing the words, "Alfred Belitz, M. D. Day, September 21, 1950, Pepin, Wisconsin. He has served us well since July, 1918."

He is survived by his widow, Emma; a sister, Mrs. Antoinette Lammers of Chicago; and several nieces and nephews.

**Dr. Joseph H. Hardgrove**, 82, a practicing physician at Eden for 32 years, died at Shawano on November 19 after a short illness.

He was born on November 25, 1870, in Fond du Lac and spent his early youth in Eden. He graduated from the former Oshkosh Normal School and also studied at the University of Wisconsin. In 1903 Doctor Hardgrove was made principal of the State Graded School at Tigerton. He later helped establish Tigerton High School and served as its first principal. After serving as principal of Manawa High School for five years, he entered Marquette University School of Medicine, receiving his degree in 1916. He was president of the Fond du Lac County Rural Normal School Board for many years and was a life member of the State Medical Society, Fond du Lac County Medical Society, and the American Medical Association. Doctor Hardgrove served in the State Assembly from 1932 to 1934.

He was honored at a "Civic Day of Appreciation" brought about by his announced intent to retire in January 1949.

Doctor Hardgrove's wife, Julia, died in 1936. He is survived by his daughter, Mrs. F. N. (Helen) Grover; two sons, Dr. Thomas J. Hardgrove, American Lake, Washington, and George W. Hardgrove, Eden; three brothers; two sisters; and eight grandchildren.

**Dr. Orvil O'Neal**, Ripon physician, died on November 24 after an illness of several weeks. Born in McLeansboro, Illinois, on July 1, 1883, he was 70 at the time of his death.

Doctor O'Neal was a 1910 graduate of the St. Louis University School of Medicine. He practiced in Ripon for 40 years, specializing in the treatment of eye, ear, nose, and throat. He was president and chief of the medical staff of Ripon Hospital, a member of the county medical censor board, Fond du Lac County Medical Society, the State Medical Society, and the American Medical Association. He was also a member of the county veterans service commission for many years. Doctor O'Neal was a veteran of World War I.

Surviving him are his widow, Hattie; three sons and two daughters; a brother and sister; and 10 grandchildren.

**Dr. Franklin B. Mead**, 45, formerly of Madison, died suddenly on November 28, at Riverside, California.

Doctor Mead was graduated from Northwestern University Medical School in 1937 and interned at the Presbyterian Hospital, Chicago, following which he held a three-year fellowship in surgery at the Mayo Clinic, Rochester, Minnesota. He moved to Madison in 1942 and was a member of the Dane County Medical Society, the State Medical Society, and the American Medical Association. In 1943 he moved to California, where he practiced until his death.

**Dr. Walter E. Meanwell**, a practicing physician in Madison for many years, died suddenly on December 2, 1953. He was born in Leeds, England, in 1884 and came to the United States at the age of 3.

Doctor Meanwell graduated from the University of Maryland School of Medicine and Baltimore Medical College in 1909 with *cum laude* honors. His internships were served at the Maryland General Hospital and Maryland Lying-in Hospitals. From 1907 to 1910 he was supervisor of athletics of the Public Athletic League of the City of Baltimore. In 1915 he received the Doctor of Public Health degree from the University of Wisconsin.

Doctor Meanwell was medical supervisor of athletic teams and coached basketball at the University of Wisconsin from 1911 to 1917. He served as Athletic Director, Director of Student Health, and basketball coach at the University of Missouri from 1917 to 1920. During the 22 years he coached basketball his teams won 10 conference championships. He served as Athletic Director at Wisconsin in 1933, 1934, and 1935.

He served as a captain in orthopedics in the medical corps in World War I and received a certificate of merit for his services in World War II. He was a member of the Association of Military Surgeons of the U. S. Army Medical Corps, the Dane County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, the Academy of Physical Medicine, and the American Congress of Physical Therapy. Doctor Meanwell was

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awarded an honorary life membership in the National Association of Basketball Coaches in 1951 and in May 1953 was awarded the Metropolitan Intercollegiate Basketball Cup presented by the National Association of Basketball Coaches for his outstanding contribution to basketball. He had been secretary of the National Basketball Rules Committee for over 20 years; chairman of the Olympic Games Committee; and author of *Basketball, The Science of Basketball,* and *Training and Care of Injuries.*

Surviving Doctor Meanwell are his widow; two daughters, Mrs. James H. Bohstedt and Mrs. Robert Ames Cooper, Madison; and one son, Walter Alan, a student at the University of Virginia.

T. W. NUZUM, M. D.

**Dr. Thomas W. Nuzum,** co-founder of the Pember–Nuzum Clinic, Janesville, died at his home there December 11 at the age of 94. He was born on a farm near Viroqua August 27, 1860. The father of three physician sons, Doctor Nuzum was widely known in Wisconsin medical circles.

Following graduation from Viroqua High School, he taught school and was for one year principal of the De Soto High School. During summer vacations, he worked with Dr. William A. Gott, a Civil War Army surgeon, who acted as his preceptor in medicine. Doctor Nuzum was graduated from Rush Medical College, Chicago, in 1885 and the following year entered practice in Albany, where he was located for one year, after which he opened an office in Brodhead, where he practiced for 15 years. In Brodhead he established a 12-bed hospital with an operating room on the third floor of his office building.

Doctor Nuzum spent most of 1905 in Vienna, Austria, studying at the Allgemeines Krankenhaus and in 1914 studied with Doctor Lane in London, England. He located in Janesville in 1906. He served as chief of staff of Mercy Hospital, Janesville, and he had been a life member of the Rock County Medical Society, the State Medical Society, and the American Medical Association since 1945. He was a fellow of the American College of Surgeons, a fellow of the Wisconsin Academy of Surgery, a member of the American Association of Railway Surgeons, and a past president of the Milwaukee Railroad Surgeons Association. Doctor Nuzum was a member of the Fifty-Year Club of the State Medical Society.

His wife, the former Jessie Richards, preceded him in death on May 6, 1950; and his son, Dr. John Nuzum, died June 14, 1953. He is survived by two sons, Dr. Franklin Nuzum, Santa Barbara, California, and Dr. T. O. Nuzum, Janesville; one daughter, Mrs. Delbert J. Worley, Janesville; nine grandchildren; three great-grandchildren; a sister; and a brother.

**Dr. Merle Q. Howard** died following a stroke on December 5, in Seattle, Washington. He was born on September 26, 1891, in Kenney, Illinois, and was 62 at the time of his death.

Doctor Howard was a 1916 graduate of the University of Oklahoma School of Medicine. He was on the staff of the Milwaukee Sanitarium, Wauwatosa, for 26 years. In 1951 he entered private practice in Milwaukee. Recently he joined the staff of a hospital in Washington.

Doctor Howard was a member of the Medical Society of Milwaukee County, the State Medical Society, the American Medical Association, the Milwaukee Academy of Medicine, and the American Psychiatric Association.

He is survived by his widow, Anita; a daughter, Mrs. Patricia Ann Manion, Milwaukee; his parents, Mr. and Mrs. E. L. Howard, Seattle; a brother, Dean, Seattle; and a sister, Mrs. Dorothy Arnold, Crystal Lake, Washington.

**Dr. Arthur W. Jones,** a general practitioner for 52 years in Randolph, died December 11 at the age of 77.

A native of Racine, he was graduated in 1901 from the Wisconsin College of Physicians and Surgeons in Milwaukee, now a part of Marquette University. He went into practice in Randolph upon his graduation and served that community until his death. He was the village health officer for 34 years.

Doctor Jones' long service to the community was recognized on June 7, 1951, when the village honored him with a parade and all-day program.

He was a member of the Columbia–Marquette–Adams Counties Medical Society, the State Medical Society, and the American Medical Association. He was also a member of the State Society's Fifty-Year Club.

**Dr. Oscar E. Lademan,** 78, who taught hundreds of Milwaukee physicians during 40 years as a professor of medicine at Marquette University School of Medicine, died December 12.

Doctor Lademan was born October 28, 1876, and was graduated from Washington University School of Medicine in 1897. After completing his internship, he practiced in Milwaukee County institutions for two years, and then he studied for a short time in Berlin and for almost three years in Vienna. Upon his return to the United States in 1902, he practiced in St. Louis for over two years and also taught medicine at Washington University School of Medicine. In 1905 he returned to his home town, Milwaukee, where he lived until the time of his death.

Doctor Lademan retired in 1946 after 30 years as medical referee of the Milwaukee agency of the Mutual Life Insurance Company of New York. After he gave up this insurance post, the physician served as medical advisor for the Blue Cross program until September 1953. Only recently he gave up his post as a medical examiner for the Wisconsin Selective Service appeal board, on which he had served since 1942.

Doctor Lademan was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association. He was also a member of the Fifty-Year Club of the State Medical Society.

**Dr. Ralph C. Hartman**, 67, a native of Brodhead and long-time Janesville physician and surgeon, died December 20 at his home in Alamo, Texas.

Doctor Hartman attended the University of Wisconsin and the University of Illinois College of Medicine, from which he was graduated in 1914. He began his practice at Newton, Kansas, and returned to Janesville in 1920 to practice.

Surviving Doctor Hartman are his widow, Margaret; two sons, Doctor Ralph, San Antonio, Texas, and Doctor Jack, Harlingen, Texas; a daughter, Mrs. Jane Morriden, Harlingen; a brother; and a sister.

**Dr. Irving V. Grannis**, a retired Menomonie eye, ear, nose, and throat specialist, died December 26 following a lingering illness. He was 71 at the time of his death.

He was born in Menomonie on July 30, 1882, and he was graduated from the University of Wisconsin in 1912. Two years later he received his medical degree from Harvard Medical School. He practiced with his father, Dr. E. H. Grannis, for two years; and after his father's death in October, 1916, he practiced alone until he was commissioned a first lieutenant in 1917. When he was discharged as a major in 1919, he joined the Menomonie Clinic. In 1931 he studied in Vienna for six months.

Doctor Grannis was a member of the Eau Claire–Dunn–Pepin Counties Medical Society, the State Medical Society, the American Medical Association, and the Wisconsin and Upper Michigan Society of Ophthalmology and Otolaryngology.

He is survived by his widow, Sybil, and a sister, Mrs. J. P. O'Malley, Bayfield.

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**Dr. T. Leroy Jacobson**, 62, Delavan, died suddenly January 3. He was born December 2, 1891, in Sugar Creek township.

He was a lifelong resident of the Delavan area and had been a practicing doctor, specializing in eye, ear, nose, and throat, in Delavan for about 30 years. He was one of the founders of the Delavan Clinic. He was graduated from Rush Medical College in 1919.

Doctor Jacobson was a member of the Walworth County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow, Betty; a son, Jon, a student at Lawrence College; a daughter, Mrs. Fred Lutz, Los Angeles; three sisters; and two brothers.

**Dr. Palle P. M. Jorgensen**, a practicing physician and surgeon since 1898, died in Kenosha on January 5. Born in Jutland, Denmark, December 18, 1872, he was 81 at the time of his death.

Doctor Jorgensen moved to western Iowa in 1880. He attended Elkhorn College and Iowa State College, Cedar Falls, Iowa. Following his graduation from the State University of Iowa College of Medicine in 1898, he started practice in Kenosha. In 1936 he moved to California, returning to Kenosha in 1939.

He was a captain in the medical division of the Army during World War I and was a former member of the Kenosha County Medical Society, the State Medical Society, and the American Medical Association. He was a member of the medical staff of Kenosha and St. Catherine's hospitals.

He is survived by his widow, Helen; a son, Paul E., Racine; a daughter, Miss Cora Lucille Jorgensen, Kenosha; and two sisters.

**Dr. Alfred M. Rosenheimer**, 70, a physician at Beaver Dam since 1929, died January 8. He was born at Slinger on January 16, 1883, and lived there until the age of 7, when his family moved to Milwaukee.

He was graduated from the College of Physicians and Surgeons, Milwaukee, in 1907. He practiced in Milwaukee until 1923, when he moved to Fox Lake. In 1929 he moved to Beaver Dam, where he prac-

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ticed until the time of his death. Doctor Rosenheimer was a member of the Dodge County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow, Mae; a sister, Mrs. Alex Luedicke, of Milwaukee; and one nephew.

F. A. STRATTON, M. D.

**Dr. Frederick A. Stratton,** 73, widely known Milwaukee surgeon, died at his home on January 13 after an illness of about a year. A native of Center, Wisconsin, Doctor Stratton was graduated from the old Wisconsin College of Physicians and Surgeons in 1903.

He practiced surgery for more than 50 years. He was emeritus clinical professor of surgery at the Marquette University School of Medicine and chairman of the surgical department of St. Joseph's Hospital at the time of his death. He was professor and head of the department of general surgery at the medical school for 16 years, retiring in 1950, and had been on the faculty for 43 years. He headed the St. Joseph's Hospital surgical department for about 30 years and had served as its chief of staff. He was a consulting surgeon at Columbia Hospital and the County General Hospital. Doctor Stratton was president of the Medical Society of Milwaukee County in 1923. He was awarded the State Medical Society's highest honor, the Council Award, in 1951.

Doctor Stratton was the last survivor of three physicians who treated the late President Theodore Roosevelt when he was shot in Milwaukee in 1912.

He was an honorary member of the Milwaukee Academy of Medicine and a member of the Medical Society of Milwaukee County, the State Medical Society, the American Medical Association, the Wisconsin Surgical Society, the Milwaukee Surgical Society, the Central Surgical Society, and the Wisconsin Surgical Club. He was a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons. He was also a member of the Fifty-Year Club of the State Medical Society.

He is survived by his widow, Irene; three daughters; a brother; and a sister.

## 1953–54 SCHOLARSHIPS AVAILABLE IN PLASTIC AND RECONSTRUCTIVE SURGERY

The Foundation of the American Society of Plastic and Reconstructive Surgery announces the regulations of the Fifth Annual Scholarship Contest:

1. The contest in Junior Classification is restricted to residents in training and to plastic surgeons who have been in practice no longer than five years.
2. Two main prizes are offered, each consisting of a three-months' plastic surgery scholarship with full maintenance in a number of selected leading services, in the United States and abroad.
3. The subject matter of the essay must be the result of some original research (either clinical or experimental) in the field of plastic and reconstructive surgery. The thesis should be of about 5,000 words, and written in English.
4. Work previously published wholly or in part is not acceptable.
5. Expenses of travel between the services will be allotted.
6. A silver plaque or a certificate of honorable mention is also offered for a winning essay in Senior Classification to contestants active in practice of plastic and reconstructive surgery for more than five years.
7. Manuscripts will not be accepted by the Award Committee after July 1, 1954.
8. The winning essays will be presented in person at a formal program of the Foundation of the American Society of Plastic and Reconstructive Surgery to be held in the fall of 1954.

For further information, write to the Award Committee, % Jacques W. Maliniac, M.D., Chairman, 30 Central Park South, New York, N. Y.

*Facts about*

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## The "Capital" Question

The mechanisms of "full payment" in the Society's Prepaid Plans are questioned by some physicians on the basis that financial capital as well as annual income should be included in the "full payment" formula. Under the present provisions of the Society's programs, family incomes of $4,800 and $3,600 are the limits within which "full payment" is applicable. Annual income is defined as the sum total of yearly wages and other compensation or income includable in federal income tax returns, except capital gains or losses. The point is made that many patients, particularly in the older age brackets, have annual incomes that may be low but do have substantial capital.

The Commission on Prepaid Plans is not without some appreciation of the validity of this argument. The matter has been an item of much concern and discussion within the Commission and particularly within the special committee which studied fees. These considerations go on continually; and, although the Society has not made any final determination, it has some opinions of how capital should be viewed in relation to the "full payment" provisions.

It is quite true that in some types of brackets there may be a disproportionately large number of elderly patients of substantial means—or capital—whose annual income may be low. However, capital might be considered as something more than investments and the like. A man in the middle age bracket, for example, has a capital in the sense that he has a period of time over which he may expect to labor and from that labor produce income. An elderly man of means is living on the product of past labors. The first has a corpus in the future which does not exist in terms of an actual, tangible, monetary substance but most certainly exists as a practical matter; the second has an earned corpus. How much difference is there, really, in these two situations?

The elderly patient is not only reluctant, but actually fears dissipation of his capital investment, the income from which accounts for his support during the balance of his lifetime. With the rapid extension of the span of life, it is little wonder that the elderly person fears loss of capital just as much as the younger individual fears physical disability that will prevent his earning to the point of normal retirement.

This is the philosophy upon which the Society's programs of health insurance are operated. Yet, it presents a complex and somewhat intangible problem that requires the best of all our thinking. A more permanent solution is needed, for it defeats the very purpose of our voluntary efforts if we are unable to assure patients throughout Wisconsin that there is virtually 100 per cent participation on the part of practicing physicians. Without a solution, it is inevitable that increased pressure will be brought about for compulsory programs. These most certainly can never be as realistic for the problems of medical care as are the voluntary plans under the direction of the profession.

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# PHYSICIANS' EXCHANGE

**Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.**

PHYSICIAN AVAILABLE: Family man, age 31, board qualified in internal medicine desires permanent association with small group or individual. Military obligations fulfilled. Community less than 25,000 preferred. Address replies to Box 537 in care of the Journal.

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PHYSICIAN AVAILABLE, starting July 1954. One year general practice residency completed. Desire to establish practice alone or as an associate in moderate-sized community. Address replies to Box 538 in care of the Journal.

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FOR RENT: Doctor's office in prosperous paper mill and agricultural community. Centrally located on Main Avenue, Kaukauna, Wis. Reasonable. Write or call A. Gerlach, 5632 W. Auer Avenue, Milwaukee 16.

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WANTED: Doctor to practice in small agricultural and industrial community of 5,500 in southwestern Wisconsin as associate of physician with large general practice. Surgical training preferred. Complete x-ray and laboratory facilities in office. Hospital facilities in town. Address replies to Box 523 in care of the Journal.

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WANTED: A recent medical graduate who is free of military obligation as an addition to a clinic of three medical men in northwestern Wisconsin, approximately 50 miles from the Twin Cities. Excellent hospital facilities with all modern diagnostic and therapeutic equipment. Fine opportunity for the right man for permanent practice and opportunity for specialization. Write, giving age, educational qualifications, health, religion, and availability. Address replies to Box 539 in care of the Journal.

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OFFICE SPACE available in a good location in down town Racine. All instruments, office equipment, and medical library of a deceased EENT specialist are at present in the office and are for sale. Good opportunity for practitioner interested in taking over the office and equipment and continuing the practice at the same location. Address replies to Mr. A. E. LaFrance, 523 Main St., Racine, Wis.

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WANTED: Young, progressive clinic in western Wisconsin needs pediatrician, certified or board qualified, and a general practitioner. Excellent opportunity. Address replies to Box 521 in care of the Journal.

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FOR SALE: Practice and fully equipped 15-room office in central Wisconsin college town of 6,000. Gross over $40,000. New open hospital in city. Excellent for 3-man group. Because of health, owner will remain on part-time basis only. Address replies to Box 522 in care of the Journal.

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FOR SALE: McCaskey Register System for physicians. Desk model, four drawers. Steel cabinet, 30½ by 17 by 32 inches. Price, $50.00. Address replies to H. G. E. Mallow, M. D., 210 Madison Ave., Fort Atkinson, Wis.

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FOR SALE: Home and office in well-established business section of Milwaukee. Two-room doctor's office and two-bedroom living quarters on first floor, three-bedroom living quarters on second floor. Owner selling because of age and poor health. For details write Dr. Frank J. Schultz, 1521 West Lincoln Avenue, Milwaukee 15, or phone MI 5–8672.

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THE WISCONSIN MEDICAL JOURNAL

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# Carcinoma of the Finger Resulting from a Wood Sliver*

By VICTOR S. FALK, JR., M. D., F. A. C. S.
Edgerton

A CASE is presented in which a very minor injury—a wood sliver beneath the finger nail—resulted in a carcinoma within a relatively short period of time.

## Case Report

The patient, a 60-year-old carpenter, was injured on March 29, 1950. While working with old wooden flooring, a sliver was forcibly driven under the nail of his right index finger. The sliver ran the full length of the center of the nail and penetrated the nail bed. He immediately extracted as much of the sliver as he could, leaving what he thought was only a black mark. He experienced no difficulty until about one year later when the finger began to ache. On May 3, 1951, he was seen by his family physician who described the finger as "swollen and the medial corner of the nail torn away. Removal of the nail revealed a lot of necrotic tissue near the nail bed which, when cleaned out, left a rather deep ulcer. Undoubtedly the sliver was never entirely removed, and the resultant difficulty was due to foreign body reaction." Further treatment consisted of penicillin and frequent dressings. Six weeks later the wound had healed, but the nail had not grown back. The patient stated that the original "black mark" persisted even after removal of the nail.

Exactly one year elapsed before the patient was seen again. On June 16, 1952, he came to my office and presented his right index finger, which by that time (27 months after the initial injury) had become a fungating, bulbous, malodorous mass. The surface was ulcerated and bled easily. Only a small sliver of nail remained. The mass had entirely replaced the distal phalanx, and there was some involvement of the middle phalanx.

Fig. 1—Photograph of finger 27 months after injury.

Roentgenological findings were described as "a large soft tissue mass involving the distal phalanx. The bony structure of the distal phalanx is almost completely destroyed. A few bony fragments remain within the soft tissue mass. The extreme proximal portion of the distal phalanx remains relatively intact. The line of demarcation is sharp. Conclusions: Probable malignant lesion involving the distal phalanx of the index finger. A

* Presented at the Wisconsin Surgical Society meeting, Madison, May 9, 1953.

Fig. 2—Roentgenogram showing bony destruction and tumor formation.

granulomatous lesion cannot definitely be excluded."

Aside from the right index finger, the remainder of the physical examination was not remarkable for a man of 62. No axillary nodes were palpated. A roentgenogram of the chest revealed no evidence of metastatic lesions. Routine laboratory examinations were within normal limits and the serology was negative. He had lost the distal phalanx of the opposite index finger in an accident 35 years ago.

On June 26, 1952, under intravenous sodium pentothal anaesthesia, an amputation was made through the proximal interphalangeal joint. There was sufficient uninvolved skin of the middle phalanx to cover the stump adequately. The patient was discharged from the hospital the following day and the wound healed uneventfully.

The pathological examination was made by Dr. M. B. Llewellyn. The gross specimen consisted of the right index finger amputated through the proximal interphalangeal joint. The appendage measured 7 cm. in length and at the distal end, which showed a bulbous swelling, 4.5 cm. in width. The skin over the superior distal portion was ulcerated in an area 4.5 cm. in diameter. Displaced posteriorly and to the right of the large ulcer was a narrow portion of the fingernail. A smaller ulcerated area was present on the lateral distal aspect just beneath the larger ulcer. The bases of the ulcers were grey and granular. A section through the center of the finger showed the entire distal end to be replaced by firm, pearly white tissue. The terminal phalanx had been completely destroyed, as had all normal architecture in the area.

Microscopically, a section through the edge of the large ulcer, described grossly, showed it to be covered by a layer of stratified squamous epithelium with thick stratum corneum. The surface of the ulcer was covered by a small amount of exudate composed of serum, fibrin, and neutrophils. The base of the ulcer was composed of neoplastic tissue which had also replaced all of the underlying tissue. Large irregular masses of poorly differentiated squamous epithelium were infiltrating a small amount of fibrous connective tissue stroma. The epithelial cells were large and polyhedral, with large nuclei and prominent nucleoli. In some of the masses well developed intercellular bridges were present between the cells, while in other masses the cells were less differentiated and intercellular bridges were absent. Keratohyalin was being produced in some areas. The centers of many of the masses were necrotic, being composed of eosin-staining debris in which ghosts of cells and scattered pyknotic nuclei were seen. The stroma showed moderate infiltration with lymphocytes. The pathological diagnosis was squamous cell carcinoma.

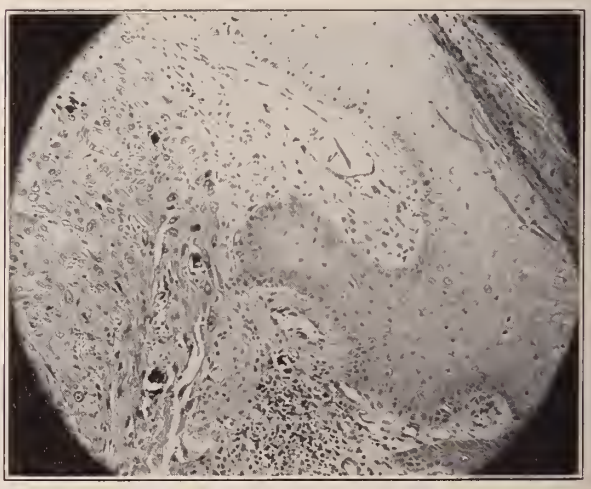

Fig. 3—Photomicrograph through edge of large ulcer.

The patient soon resumed his regular work and was able to utilize the stump with little disability. A photograph at six months shows a satisfactory result. Postoperative examinations, at six and ten months, revealed no evidence of metastases.

### Carcinoma of the Hand

Mason,[1] Bunnell,[2] and Cutler[3] all have presented closely comparable figures in the incidence of carcinoma of the hand. Only 10 per cent of all cutaneous carcinomas occur on the hands. The ratio of incidence in males is about 2 to 1 over that in females, and the proportion of right over left hands is about the same. The dorsum of the hand is more often affected than the palmar surface. In Mason's[1] series of 239 cases of carcinoma of the hand, the average age was 59. He also found the upper extremity affected two to three times more frequently than the lower, stressing the significance of trauma.

Cutler[3] states that 80 per cent of recorded cases of cancer of the hand follow some form of antecedent local irritation. The remaining 20 per cent of these tumors originate in normal skin. X-ray, radium, and solar irradiation are well-recognized external irritations. External chemical irritations would include paint, tar, grease, oil, gasoline, pitch, acids, alkalis, and paraffin. The long continued use of Fowler's solution is listed as an internal chemical irritation. Scar tissue irritation is a rather common cause of carcinoma. This is seen most often in old burn scars. Mason[1] found the average time elapsing from the date of the burn to the development of the carcinoma to be 43 years. He also reported that carcinoma occurs in lupus scars in about 3 per cent of the cases of that disease. The irritation may be from a single trauma or a chronic infection such as an osteomyelitic sinus, luetic ulcer, chronic paronychia, or carbuncle and furuncle. Carcinoma also may arise in previous skin tumors such as keratoses, warts, nevi, and congenital neoplasms. Carcinoma of the fingernail, arising from the nail bed or groove, is rare. According to Bunnell[2] only 13 cases were reported up to 1939.

Carcinoma of the hand is characterized by a long chronic course, often ulcerating for a year or two. The ulcer or cauliflower mass enlarges slowly, involving the adjacent skin and subcutaneous tissue. Eventually tendon, bone, and muscle are invaded, although this may be late and only after the original lesion has attained large size. These tumors usually become infected and necrotic, and a malodorous discharge results. Occasionally severe hemorrhage is seen when a vessel is eroded. The involvement of lymph glands is often late and may be two to three years after ulceration occurs. The presence of nodes does not necessarily indicate metastases, since the infection is often the cause.

Fig. 4—Photograph six months after amputation.

Pathologically the majority of these tumors are squamous cell carcinomata, the remainder basal cell. The gross appearance varies from small fissures to areas of hyperkeratosis or actual exuberant cauliflower formation with or without ulceration. The majority are of low-grade malignancy. The occurrence of pain in an ulcer or sinus after a period of quiescence is suggestive of the onset of malignancy.

The prognosis in these cases is relatively good because of the long, slow course before extension and metastases occur. However, this carcinoma is invasive and produces lymph nodes and generalized metastases if not removed. Mason's[1] breakdown of statistics, according to etiological factors, reveals that the best prognosis is in cases where the carcinoma arose in previously normal skin without any known preceding factor. The next best prognosis is in the cases of carcinoma following the irritative lesions. A

carcinoma arising from a previously existing neoplasm or wart presents the worst prognosis. If the original neoplasm is congenital, the outlook is as bad as in malignant melanoma.

The most important phase of treatment in carcinoma of the hand is prophylaxis. This consists of the eradication of all types of chronic irritation or infection. Attention to warts, nevi, keratoses, old scars, granulomas, and ulcerative lesions is essential. If changes, such as scars from burns or roentgen dermatitis, have already occurred in the skin and are likely to persist and result in malignant degeneration, the involved skin should be removed and replaced by normal healthy skin. Once a cancer has developed, early and radical removal must be undertaken. The resection should include any areas of skin which might later break down. Cutler[3] recommends a general anaesthetic because local infiltration in the region of malignant growth may disseminate tumor cells. If epitrochlear or axillary nodes are palpable, their complete removal by dissection must be done, although 50 per cent of these will not be malignant. Mason[1] states that there are no recorded cases of metastatic growth in these glands from carcinoma of the hand if they can not be felt. When the carcinoma has invaded the deep structures of the hand or finger, and in cases of granulomatous carcinoma of the nail bed, an amputation of the affected part is indicated. Irradiation has been used to supplement surgical treatment, and is often helpful when the condition is inoperable.

Medicolegal problems often arise when a malignancy develops following trauma. Ewing[4] has suggested that the following criteria be applied in each case of this type:

1. Continuity of symptoms of the injury with those of the tumor.
2. The authenticity and adequacy of the trauma.
3. The previous integrity of the wounded part.
4. The origin of the tumor at the exact point of injury.
5. A reasonable time limit between the injury and origin of the tumor.
6. The type of tumor resulting.

### Summary

Carcinoma of the hand occurs most often after an antecedent external local irritation. This may be a single trauma or chronic infection. The lesion is characterized by a chronic course and late metastases. The best treatment is the prophylactic eradication of irritation or infection. Once a cancer has developed, radical removal is necessary.

A typical case has been presented which illustrates the etiological role of trauma and chronic infection following a single minor injury (a wood sliver beneath the fingernail). Within two years an extensive squamous cell carcinoma developed at the site of injury, necessitating amputation of the finger. The need for prompt, proper treatment in cases of this type is apparent.

---

Shearer Clinic.

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3. Cutler, W.: The Hand, Its Disabilities and Diseases, Philadelphia, W. B. Saunders Company, 1942, pp. 453–459.
4. Ewing, James: Neoplastic Diseases; a Treatise on Tumors, Philadelphia and London, W. B. Saunders Company, 1940, p. 108.

## SPRING MEETING OF OBSTETRICS AND GYNECOLOGY GROUP ANNOUNCED

The Wisconsin Society of Obstetrics and Gynecology will hold its spring meeting on May 22 at the Northland Hotel, Green Bay. All physicians interested in the subjects of obstetrics and gynecology, even though not members of the society, are cordially invited to attend.

The program will begin at 9:00 a.m. and conclude at 4:00 p.m., with luncheon during the noon hour. The complete scientific program, being arranged by W. V. Luetke, M.D., Madison, will be announced in the next issue of the *Journal.*

To facilitate planning for the luncheon, it is suggested that all those who will attend write Dean D. Willson, M.D., Secretary, Wisconsin Society of Obstetrics and Gynecology, 92 East Division Street, Fond du Lac.

# The Treatment of Headache with Cafergot Suppositories*

By FRANCIS J. MILLEN, M. D.
Milwaukee

## Introduction

SINCE the advent of newer, specific drug therapy of headaches, research has been directed along the lines of more effective methods and routes of drug administration. Admittedly, the ergot preparations have been the singular, most effective drug in the therapy of severe, recurrent, incapacitating headaches of various types.[1] Unfortunately, in some cases these oral ergot preparations themselves have been associated with symptoms of nausea and vomiting. Many recurrent headaches, particularly of the migraine variety, are associated with nausea and vomiting as a part of the syndrome. Frequently the vomiting has prevented complete absorption of the medicament. Accordingly, the rectal suppository route of administration has been utilized. Previous reports have verified the effectiveness of this route.[2-5] The present report describes this author's results with rectal suppositories named EC 112* and ECBP 163* in a selected group of severe headache problems.

## Materials and Methods

Twenty-seven private cases were chosen during a two-year period to determine their clinical response to these rectal suppositories containing ergot derivatives. The patients were chosen from a large group seen in private neuropsychiatric practice. All age groups were used, and the ages varied from 12 to 67 years. Headache was the principal or chief complaint of the patients used in this series. Only those headaches definitely present for a long period of time and having a fairly well-established pattern and frequency were treated. The nature of the headache, its origin, etiology, and associated factors were carefully determined. The pattern of the headache attacks, their frequency and duration, as well as the severity of the pain and its incapacitating degree, were all carefully evaluated and charted. In this way a careful estimate of drug effectiveness could be determined. Precipitating factors and aggravating events were carefully considered.

An objective, non-directive approach was used in handling these patients. The psychotherapeutic effects were kept at a minimum as much as is possible in a therapeutic relationship of this sort. From the beginning, the author was aware of the possible psychological effect brought about by the use of suppositories in anal erotic patients who frequently have headaches as a presenting complaint. This factor was carefully evaluated in the procedure and was checked with placebo suppositories.

TABLE 1—*Previous Drugs Used by Patients*

| | |
|---|---|
| Cafergot | Barbiturates |
| Gynergen | Chloral |
| $DHE_{45}$ | Coal Tar Derivatives |
| Octin | Dramamine |
| Niacin | Dilantin |
| Histamine | Codeine |

After a careful general medical examination by the referring physician supplemented in the neurological examination, a complete neurological and psychiatric examination was made. Nearly all the patients used in this series had been given most, if not all, of the usual drugs used in the treatment of headaches. An incomplete list of some of these drugs previously used is seen in Table 1. The effectiveness of previous medication was carefully evaluated. In all cases treated, the headaches had been resistive to the best of modern therapy. Accordingly, this series of cases represents carefully chosen severe, intractible, incapacitating headaches which had previously failed to respond to treatment.

The importance of correct diagnosis and classification of the type of headache and previous treatment used in evaluating the results of any new therapy guided us in the careful and complete workup of each case.

*Material supplied through courtesy of Sandoz Pharmaceuticals.

EC 112 (Contents): 2 mg. ergotamine tartrate and 100 mg. caffeine.

ECBP 163 (Contents): Pentobarbital sodium, 60 mg., ergotamine tartrate, 2 mg., Bellafoline substance, 0.250 mg., and caffeine, 100 mg.

A summary of the differential diagnosis and clinical workup utilized in this series is seen in Tables 2 and 3.

Cases of organic or symptomatic headache (secondary to brain tumor, aneurysm, hematoma, arteriosclerosis, etc.) were not used in this series. Because of the contraindications of ergot preparations in such cases, patients having hypertension, organic heart disease, obliterative vascular disease, or pregnancy were also excluded.

TABLE 2—*Differential Diagnosis of Headache*

| Cause | Cause |
|---|---|
| Psychogenic—Tension | Intracranial |
| Systemic Disorders | Toxic |
| Hypertension | Cerebrovascular |
| Blood Disorders | A.S.—Aneurysm, etc. |
| Infections | Infections |
| Hypothyroidism | T.B., Lues, etc. |
| G. I. Disorders | Trauma |
| Periarteritis Nodosa, Etc. | Hematoma, etc. |
| Extracranial—Cervico-Cephalgia | Space-Occupying |
| Ocular | Neoplasm |
| Paranasal Sinuses | Histaminic-Cephalgia |
| Temporal Arteritis | Migraine |
| Neuritis—Neuralgia | |
| Arthritis—Disc | |
| Myositis—Fibrositis | |

Following the clinical and laboratory workup of the patient and the established diagnosis, the patient was instructed in the use of the suppository. In the episodic, recurrent headaches, the patient was instructed to take one suppository at the onset of the headache or the aural symptoms. If no relief was obtained, another suppository was taken one hour later. In several cases, particularly those in which the headache had become more or less intractible and daily, a prophylactic suppository was given at night. Many patients soon found that one half or one third of a suppository at bedtime would suffice to prevent a headache on awakening. After the cycle of headache was broken, the patient could then use the drug only symptomatically or at the onset of a headache. Because of the possible habit-forming properties of ergot preparations,[6] patients using more than a few suppositories each month were checked more carefully, and placebo suppositories were substituted.

In instances where excellent results were obtained, the placebo suppositories were substituted. When placebo medication was used, the patients invariably called soon after starting on the new medication and complained that the new suppositories were no longer effective and that the headache had returned or no longer was relieved by the suppository. In some instances, adjunctive prophylactic therapy was added, using almost routinely 50 to 200 mg. of niacin three or four times a day orally and Donnatal, one tablet three times a day. Such prophylactic therapy was used in those patients who had episodic, recurrent headaches to lessen the frequency of the attacks.

TABLE 3—*Clinical Workup in Diagnosis of Headache*

| | |
|---|---|
| Careful History | Search for Etiological Agents |
| Description of Attack | Food |
| Review of Systems | Alcohol |
| | Tension |
| General Physical Examination | |
| Neurological Examination | Provocative Tests |
| | Histamine |
| Psychiatric Evaluation | Special Tests When Indicated |
| | X-ray of Skull, Neck, Sinuses |
| Personality Study | Electroencephalogram |
| | Spinal Fluid |
| Routine Laboratory Tests | |
| Blood | Neurologist's Consultation |
| Urine | When Indicated |
| Serology | Then: Neurosurgical Studies |
| B.M.R. | |

An account was kept of the patient's response and any untoward reactions that occurred while the patient was using the suppositories. When side reactions to EC 112 were noted, the patient was given a suppository of Belladenal* to use along with the one causing the reaction. Attention was paid to the reduction in frequency, nature, and severity of the headache attack. The results were all tabulated and can be seen in Table 4. All cases were followed for a minimum of 4 months and some for as long as 24 months.

TABLE 4

| Headache Type | Patients | Drug | Relief | | | |
|---|---|---|---|---|---|---|
| | | | Excellent | Good | Fair | Poor |
| Migraine | 13 | EC 112 | 3 | 5 | 4 | 0 |
| | | ECBP 163 | 4 | 3 | 1 | 0 |
| Tension | 13 | EC 112 | 2 | 2 | 1 | 8 |
| | | ECBP 163 | 0 | 2 | 2 | 2 |
| Histaminic-Cephalgia | 1 | EC 112 | 0 | 0 | 1 | 0 |
| | | ECBP 163 | 0 | 0 | 0 | 0 |
| Total: | 27 | EC 112 | 5 | 7 | 6 | 8 |
| | | ECBP 163 | 4 | 5 | 3 | 2 |
| | | Either Drug Used | 7 | 9 | 4 | 7 |

* Belladenal—Each suppository contains: Phenobarbital, 0.1 Gm., 'Bellafoline' (calculated as 1-hyoscyamine), 0.5 mg.

### Discussion

Considerable data already fills the literature concerning the physiological basis for headache.[7-9] The therapeutic action and effectiveness of ergot preparations in the treatment of headaches has been previously described in the literature.[1] These data will not be reiterated at this time. It is considered that the effectiveness of these suppositories was directly related to the drug contained in them and not to any psychotherapeutic effect. The effectiveness was enhanced by the absorbability of the product and the lack of loss through vomiting.

### Results

A total of 27 cases was studied in this series. The clinical diagnoses included migraine, tension, and histaminic-cephalgia headaches. The results are tabulated as excellent, good, fair, and poor. Excellent signifies complete relief of all headaches shortly after their onset or a marked decrease in frequency of headaches over a long period of time; good represents 50 per cent to 75 per cent relief in terms of reduction in frequency or severity of the headaches; fair represents 25 per cent to 50 per cent reduction in severity and frequency; and poor represents no relief or less than 25 per cent relief obtained. The duration of the headaches used in this series was from 1 to 50 years. Interestingly, the duration of the headaches did not necessarily affect the effectiveness of the drug. Headaches of long duration seemed to respond as well as those of short duration. Indeed, patients with headaches of 50, 40, 20 and 14 years' duration obtained excellent results (See Table 5). The degree of severity of the attack did not seem significant, either.

TABLE 5

| Headache Type | Duration in Years | Frequency of Attacks |
|---|---|---|
| Migraine—13 cases | 50, 6, 20, 10, 17, 6, 18, 10, 14, 25, 10, 30, 30 | Daily to Twice a Month |
| Tension—13 cases | 3, 10, 20, 4, 40, 1, 14, 1, 4, 12, 2, 2, 8 | Daily to Once a Week |
| Histaminic—1 case | 8 | Once a Week |

Of most importance was the presence of an aura or prodrome stage of the headache attack. Such an aura afforded the patient an opportunity to use the suppository before the headache had reached its peak. In general, the migraine group of patients responded much better to therapy than the tension group. No failures or poor results were obtained in the migraine group (Table 4). On the other hand, less favorable results were true in the tension group (Table 4). Where one or the other suppository was used, the results for the group as a whole were excellent, 7; good, 9; fair, 4; and poor, 7. (Table 4).

Side reactions to the drugs were less frequent with rectal suppositories than with oral preparations containing the same ergot derivatives. When side reactions occurred, the history of that case revealed intolerable reactions to oral ergot preparations as well.

TABLE 6

| Side Reactions to Suppository EC 112 | Frequency |
|---|---|
| Generalized Weakness, Malaise | 4 |
| Tremulousness, Tension | 1 |
| Nausea | 3 |
| Emesis | 1 |
| Dizziness | 2 |
| Itching | 1 |

Note: Six patients out of twenty-seven treated with EC 112 had above reactions. In 3 of these, the side reactions necessitated discontinuing the drug.

On the other hand, many patients who had had unfavorable reactions to the oral preparations tolerated the rectal suppositories quite well. In this manner these rectal suppositories have a distinct advantage over irritating oral tablets. When reactions did occur, they were usually in the form of nausea, generalized weakness, tremulousness, etc. (See Table 6). These side reactions occurred in 6 patients. They occurred only with the suppository of EC 112 and not with ECBP 163. In only three instances did the side effects require discontinuing the drug. In the other cases the supplemental Belladenal suppository lessened or prevented the side reaction.

The results obtained in this therapeutic study indicate a definite advance in the treatment of otherwise unmanageable headaches. They compare favorably with other reports in the literature.[2-4] Considering that all patients chosen in this series represent extremely difficult cases to manage clinically, with severe, intractible headaches of long duration and a very well-fixed pattern, one would expect very little response to any new medication. The results in many of these cases were most gratifying not only to the patient but also to the private physician. Admittedly, this series of cases is rather small; however,

the fewer number of cases and long period of follow-up of most cases afforded a better opportunity for more detailed and careful observation.

Cafergot suppositories should be a welcome addition to the physician's armamentarium in the treatment of the common headache of various types. This method of administration would seem particularly indicated where, because of nausea and vomiting induced by oral medication or by the headache syndrome itself, complete absorption of the ergot preparation is thwarted. Contraindications for the use of these suppositories remain the same as for other ergot preparations. If failures in therapy of headaches are to be minimized, the careful choice of patients and the careful and complete clinical and laboratory workup of the headache case cannot be overemphasized. Such preliminary procedures, along with the proper timing of medication, will do much to lessen the causes for therapeutic failure regardless of which drug is used.

## Conclusion

Cafergot suppositories have been found useful in the treatment of severe, otherwise unmanageable headaches, particularly of the migraine or vascular type.

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# Evaluation of Some Diagnostic Methods in the Examination of Neuromuscular Anomalies of the Eyes*

By HERMANN M. BURIAN, M. D.**
Iowa City, Ia.

TO CONDUCT a rational examination of the neuromuscular system of the eyes it is necessary to be thoroughly acquainted with the essence of the tests and to know how to apply them. This may seem to be a trite statement and yet it must be made, for in spite of their simplicity, the tests used in the diagnosis of neuromuscular anomalies of the eyes can be very misleading unless they are properly understood and performed.

The aim of these tests is to obtain a comprehensive picture of the condition of the neuromuscular apparatus of the patient's eyes. We must first establish whether or not there is a relative deviation of visual lines of the patient. If there is a deviation, we want to know whether it is latent or manifest. If the deviation is latent, we must investigate the direction and amount of the deviation, the status of the motor cooperation, and the status of the sensory cooperation. If the deviation is manifest, we must establish whether it is comitant or incomitant. If it is comitant, we must again determine the direction and amount of the deviation and study its nature, the behavior of the rotations, and the status of the binocular cooperation. If the deviation is paralytic, we shall want to find out, in addition to the direction and amount of the deviation, which muscle or muscles are involved.

We can accordingly classify the tests devised for the investigation of the neuromuscular status of the eyes as follows:

a. Tests to determine the presence of a latent or manifest deviation;
b. Tests to determine direction and amount of deviation (in primary and other positions of gaze);
c. Tests to determine the motor cooperation of the eyes;
d. Tests to determine the sensory cooperation of the eyes.

These tests are generally classified into objective and subjective tests. By *objective tests* are meant such tests in which the observation and measurement are made by the ophthalmologist and the cooperation of the patient is reduced to a minimum, usually to steady fixation. In the *subjective tests* the patient's response to the test situation determines the result. The opinion is widespread that objective tests are more reliable and therefore preferable to the subjective tests. This is not justified. Some subjective tests have a considerably greater intrinsic accuracy than the corresponding objective tests. Also, the assumption that the patient is a less keen or more biased observer than the doctor is not necessarily correct. The truth of the matter is that both types of tests are indispensable to obtain a complete picture of the neuromuscular system of the patient. If the examiner is aware of the pitfalls inherent in the tests—both the objective and subjective ones—he will be able to evaluate the tests properly.

I will not review all the tests which have been devised for the investigation of the status of the neuromuscular system of a patient but will discuss some of the principles which should guide us in this investigation, point out the essence of the most important tests, and list the more common pitfalls in their application.

If a latent or manifest deviation has been found to be present, by inspection or by the cover-uncover test, then its direction and amount must be determined. To this end we have at our disposal both objective and subjective tests.

Among the objective tests the alternate cover test, or prism and cover test, is deservedly popular among ophthalmologists. In this test a cover is placed alternately in

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front of each eye, while the patient maintains fixation. The eye which is being uncovered makes a movement of redress which is always in the direction opposite to the deviation. The amount of the deviation is determined by the strength of the prisms, placed in front of the eyes, which offsets this movement.

The movement of redress in the cover test is a psycho-optical reflex movement occurring when an eye assumes fixation. The sensory origin of this reflex movement is the stimulation of a peripheral retinal area in the deviated eye by the fixation object. The intent of fixation results in a turning of the eye in such a way that the fixated object is imaged on the foveal area. This movement is quantitative; it is directly proportional to the distance of the stimulated peripheral area from the fovea. One can say that each retinal element has a retinomotor value which is the greater, the farther removed the retinal element is from the fovea, the retinomotor value of the fovea being zero. By placing prisms of increasing strength in front of the eyes the image of the fixated object is brought nearer and nearer to the foveal area, with corresponding decrease in the movement of redress. When the prism strength equals the angle of squint, *i.e.*, when the image is brought to lie on the fovea, the movement of redress ceases.

This movement is also absent or unreliable and the test, therefore, not applicable when the patient will not or cannot fixate, *i.e.*, when the patient is too young or does not pay attention, when central vision is so poor that there is no "reward" in performing a movement of redress (so-called eccentric fixation), or in the presence of a latent nystagmus.

It must furthermore be pointed out that there are limits to the accuracy with which the deviation can be measured in the prism and cover test owing to the difficulties of detecting small movements of the eyes. It has been shown that under ideal conditions (proper illumination of eyes, trained observer, cooperative patient) the lowest values which can be observed are around 2 prism diopters; in most cases this value is probably somewhat higher.

There are no technical difficulties to this test and, especially in heterotropias, the results are reliable. But for all its simplicity, it must be used with care, particularly in patients with heterophoria, to arrive at the correct answer. Patients with heterophoria have a strong compensatory innervation which normally keeps their eyes straight. This compensatory innervation is not immediately given up when one eye is covered, and it is necessary to dissociate the eyes for some time to bring out the full amount of the deviation. This can usually be done if the cover is alternately placed over the eyes a few times and the test is not performed too hurriedly. The patient must never be permitted to regain fusion while the cover is being transferred. In patients with exophoria it is often necessary to occlude one eye for 10 or 15 minutes to achieve dissociation. One frequently finds that after this period the angle of deviation is considerably larger than it was before the occlusion. When this is the case, I repeat the occlusion until no further increase occurs.

Another way of insuring dissociation and of obtaining the full amount of the deviation is to continue adding prisms not only until the movement of redress is stopped, but also until a reversal of the movement is noted. This technic should always be followed.

To acquire information about the nature of the deviation, the prism and cover test should be performed both while the patient wears his refractive correction and with his correction removed, and for distance (20 feet or preferably more) and near fixation (33 cm.). The comparison of the four figures thus obtained allows conclusions about the part played by the accommodation; in other words, the figures represent the static and the dynamic angles of squint.

Proper dissociation of the eyes, determinations made in distance and near fixation and with and without refractive correction are also essential in the tests devised for the subjective measurement of the deviation.

In these tests the relative position of the eyes is determined by noting how the patient localizes the visual impressions reaching his two retinas. This presupposes, of course, that the patient localizes normally, *i.e.*, that he possesses normal retinal correspondence.

To the dissociation of the eyes there is added in the subjective tests a differentiation of the fields of vision of the two eyes by colors or by presentation of different contours. There are two types of these tests. In the first type a single object, *e.g.*, a small light source, serves as the stimulus for both

eyes, reaching different retinal areas in the two eyes, the fovea of the fixating eye and an extrafoveal area in the deviated eye. Such a situation is realized in the diplopia test and the Maddox rod test.

In the second type two unlike stimuli are provided, one for each eye. The patient has to adjust these in such a way that each stimulus falls on the fovea of the corresponding eye. Examples of this type of test are the Lancaster red-green test, the Hess screen test, and tests with major amblyoscopes.

In the diplopia and Maddox rod tests the patient fixates a small light source with one eye, while the other eye is covered with a colored filter or a Maddox rod. If the eye behind the filter is deviated, the light source is not imaged on the fovea, but on some extrafoveal retinal area. This extrafoveal area has a different visual direction than the fovea of the fixating eye (they are non-corresponding or disparate) and the test results in diplopia.

The diplopia reported by the patient indicates not only that the covered eye is deviated and in what direction it is deviated, but it also reveals the amount of the deviation. The distance of the double images is in fact one of the most accurate and sensitive measures of the deviation. This test has greater intrinsic accuracy than the prism and cover test.

The measurement itself can be performed in two ways—either by the use of a tangent scale, or better still, a tangent screen from which the patient reads off the distance of the two images, or by offsetting the diplopia with prisms. The latter method is somewhat less accurate and occasionally presents difficulties because of foveal suppression and the like.

In performing diplopia and Maddox rod tests it must be remembered that the filter serves a twofold purpose. It provides color differentiation, and it is a means of dissociating the eyes. For the latter purpose it is essential that the filter be sufficiently dark to prevent fusional stimuli from reaching the two eyes; in other words, nothing but a small red light or a streak should be perceived by the eye carrying the filter. Failing this, the full amount of the deviation cannot be elicited, especially in patients with heterophoria. It can actually be shown in some patients how the deviation increases when using filters of increasing density.

If a light red filter is employed, as in the diplopia test recommended by some branches of the Armed Services, we actually do not measure the deviation, but the readiness with which the eyes of a person will dissociate. For those whose fusion power is not strong, even a slightly tinted filter is sufficient to cause a dissociation (though it may not be complete). It may be of importance to know this in selecting personnel for specialized activities; but if we want to measure a patient's deviation, as we do daily in our offices and clinics, then maximum dissociation is required. This is achieved by using dark red filters and is further helped by frequent alternate covering of the eyes.

The dissociation may be assisted by adding a vertical prism of 5 to 10 prism diopters base up or down to the filter. This also helps to throw the image out of the area of suppression, where suppression interferes with the test, and to check on the accuracy of the statements of young or unreliable patients.

The test should always be performed by placing the filter first in front of one eye and then in front of the other and comparing the results. This is of great importance because of the relatively frequent occurrence of a dissociated vertical divergence, because of possible incomitance, and—in anomalous correspondence—because of changes in the mode of localization which may occur with change in fixation. If this rule is not adhered to, regrettable diagnostic and therapeutic errors may occur.

Turning now to the motor cooperation of the eyes, I wish to consider the measurement of the vergences or fusional movements.

These measurements are significant because they inform us of the latitude which a patient has in coping with his heterophoria, and tell us to what degree there exists binocular cooperation in patients with heterotropia.

It is important to keep in mind that the vergences consist essentially of a shift in the tonus of the extraocular muscles. Being tonic rather than tetanic, the fusional movements are slow; and changes in the tonus of the muscles, once produced, do not disappear abruptly with the cessation of the stimulus. In the case of the vergences, which are psycho-optical reflexes, this stimulus is given by disparities of the retinal images. Such disparities can be created artificially by using prism ladders or rotary prisms, or by mov-

ing the arms of a major amblyoscope, all of which shift the images on the retinas. The eyes will follow these displacements of the images by making refixation movements; and we can in this way determine the break-point, the recovery point, and, if we so desire, the blur point.

In measuring the vergences it is necessary to increase and decrease the prism power slowly. It takes appreciable time for the eyes to follow the stimulus. If the rotary prisms are turned quickly, the compensatory innervation does not have a chance to develop and to assert itself and spurious results are obtained. Because of the fact that the effect of an artificially induced fusional movement lasts for some time after the stimulus is removed, it is not advisable to measure vergences of opposite sign immediately following one another; if divergence is measured immediately after a strong convergence impulse has been exerted, its amplitude will appear much smaller than it actually is. It is therefore a good scheme to alternate the measurement of the horizontal and vertical vergences in performing the test.

Another point which should be made and which is not always properly recognized is that in measuring vergences with a rotary prism, the figures obtained have no significance unless they are correlated with the measurement of the patient's heterophoria. For example, if a patient has 8 prism diopters of prism convergence and 24 prism diopeters of prism divergence for distance, this in itself indicates neither a convergence insufficiency nor a divergence excess. For if such a patient has an exophoria of, say 18 prism diopters, this means that he must overcome this amount to begin with, in order to keep his eyes straight, and he actually has a convergence power of 18 + 8, namely 26 prism diopters and a divergence power of 24 — 18, namely 6 prism diopters. The zero mark on the rotary prism has no physiologic significance. Nevertheless, the prism convergence findings indicate that this patient will have trouble if greater need for convergence should arise; and this is usually shown by insufficient prism convergence for near. I want to take this opportunity to emphasize the importance of measuring the vergence amplitudes for near. This is all too often neglected, yet it is absolutely essential to obtain a picture of the patient's condition.

The result of the measurement of the vergences is not only influenced by the way in which the measurements are made but by the whole stimulus situation. The more fusible material there is in the field of vision, the larger the amplitudes tend to be. If the vergences are measured in a darkened room with nothing but a small light visible to the patient, he will ordinarily show smaller amplitudes than in a brightly lit room with many contours visible and some object, such as a single letter, used for fixation.

The influence of the fusion stimuli present in the field of vision is also of importance in evaluating the binocular cooperation of a patient by means of a stereoscope. Stereoscopes are used by many ophthalmologists for diagnostic purposes, and for this they are very adequate. It is, however, important that the appropriate card be chosen. For instance, in a patient with high exophoria we should always begin with cards containing fusible or preferably stereoscopic contours. With such targets the patient may show that he has good fusion and even stereopsis. With dissimilar targets he may not be able to achieve superimposition, he may have alternate suppression, etc. Such a patient needs a very strong stimulus to make his eyes cooperate; and if only dissimilar targets are used, an incomplete picture of his binocular cooperation is obtained.

I wish now to summarize briefly the tests with which the status of the retinal correspondence is determined. All these tests are by necessity subjective.

As I have pointed out regarding the subjective determination of the angle of squint, we can achieve this either by measuring the diplopia when two disparate retinal areas are stimulated (as in the red glass or Maddox rod tests) or by determining the objective position of the stimuli which fall on the two foveas and are localized in the same visual direction, since the foveas are corresponding areas. This situation obtains for instance, in the Lancaster red-green test.

Now in anomalous correspondence the retinal relationship is upset. A shift in visual directions occurs so that corresponding retinal areas (*e.g.*, the two foveas) have no longer the same visual direction, while at the same time normally disparate retinal areas (such as the fovea of the fixating eye and a peripheral area in the deviated eye) acquire a common visual direction. The tests for

anomalous correspondence are based on one or the other of these features of anomalous correspondence and can be accordingly divided into two groups.

In the first group of tests the visual direction of the two foveas is determined by simultaneous stimulation. To this group belong the after-image test, the test with the major amblyoscope with the arms set at the objective angle of the patient, and the Lancaster red-green test with the test lines displaced according to the patient's angle of squint. If the visual direction of the foveas is identical (*i.e.*, if the correspondence is normal), the after-images form a cross and the patient superimposes the targets of the major amblyoscope and the lines in the red-green test. If the foveal visual directions differ (anomalous correspondence), the after-images, the amblyoscope targets, and the lines in the red-green test will appear displaced relative to each other.

In the second group of tests the visual directions of the fovea of the fixating eye and of a peripheral retinal area in the deviating eye are simultaneously determined. To this group belong the diplopia test, the test with the major amblyoscope with the arms of the instrument at zero, and the red-green test with the test lines superimposed at zero. In all these tests the test element seen by the deviated eye will be displaced according to the angle of squint if the visual directions of the stimulated retinal areas in the two eyes have different visual directions (normal correspondence). If these two areas have a common visual direction (anomalous correspondence), the test elements are either aligned (harmonious anomalous correspondence) or only slightly displaced (unharmonious anomalous correspondence).

In conclusion I wish to bring out some general points which seem to be worth mentioning. One concerns the accuracy for which one should strive. We wish to be, of course, as exact as possible; but a pretended accuracy which is not warranted by the intrinsic accuracy of the methods employed is misleading. Thus an attempt to determine the angle of squint by the prism and cover test in steps of one half is not only unnecessary, but also impossible, because the method is accurate only within two. Aside from the limitations imposed by the method, the angle of squint and other characteristics of strabismus are variable. It is therefore necessary, and I cannot emphasize this strongly enough, to test a patient repeatedly before major therapeutic decisions are made. Only continued, careful observation will fully disclose the nature of the patient's condition and permit treatment which will be truly a satisfaction to both patient and doctor.

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University Hospitals.

## ANESTHESIA AND ANALGESIA

Physicians attending births can provide valuable information by carefully recording anesthetics and analgesics that were used under Item 29 on the latest birth and fetal-death certificates. This data is being collected and tabulated at the request of the State Medical Society's Division on Maternal and Child Welfare, which is currently undertaking special studies on maternal and fetal-neonatal deaths.

One of the problems encountered has been the reporting of such non-specific items as "General," "Gas," "Routine," "Ob," or just a "√" or "X." Even worse is no entry at all—which could mean the type of anesthetic and analgesic was not indicated or that none was used.

Information gleaned from birth certificates in the past has been valuable to all practicing physicians in Wisconsin. It has broadened knowledge of problems and helped to direct effort toward improved care which has reduced maternal and infant deaths. To be of real value, information collected must be meaningful. We therefore urge all physicians attendant at deliveries to help by entering the *specific* anesthetic and analygesic or "None" if none was used.—ROBERT PURTELL, M. D., *Chairman, Division on Maternal and Child Welfare.*

# Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

## REPORT OF A CASE*

**Dr. Robert C. Meade** (Resident in Internal Medicine): The case is that of a 27-year-old white male who was admitted to this hospital on August 6, 1952. The history was felt to be somewhat unreliable because the patient was mentally confused and contradicted his story frequently. However, he stated that he had been well until June 1952, when he noted anorexia and easy fatigability. He had several episodes of shaking chills, lasting from 15 to 20 minutes and followed by fever and profuse diaphoresis. During the latter part of July 1952 he begin to have severe generalized headaches and vomited repeatedly. About August 1 he was admitted to another hospital in Milwaukee where various diagnostic studies were done. These included an intravenous pyelogram and an attempted gastrointestinal series which was unsuccessful because of the patient's inability to keep the barium mixture in his stomach. He had lost approximately 25 pounds between the onset of his illness and the time of hospitalization. After a diagnosis of metastatic carcinoma of the lungs was made, the patient was transferred here for further care. A physical examination at that time revealed a well-developed, well-nourished, white male who appeared chronically ill. He was somewhat confused and uncooperative, and his memory was poor. He appeared weak and pallorous; but the temperature, pulse, and blood pressure were within normal limits. Funduscopic examination revealed bilateral papilledema, more marked on the left. The neck motion was of normal range, but there was some stiffness present. There were crepitant rales at the right lung base which persisted after coughing. A firm, non-tender, non-movable mass, which was about the size of a small grapefruit and was somewhat nodular, was present just below the umbilicus. The liver and spleen were not palpable. There were no peripheral nodes palpable. The remainder of the physical examination was essentially within normal limits. The white blood cell count was 5,700 with 72 segmented, 10 stabs, 13 lymphocytes, 4 monocytes, and 1 eosinophil. The hemoglobin was 14 Gm., and the sedimentation rate was 53 mm. per hour. The red cells showed basophilic stippling. An occasional red blood cell and white blood cell were found in the urine, which was otherwise negative. Wassermann and Kahn reactions were negative. On August 25 the white blood cell count was 4,800, with a differential of 1 stab, 95 segmented, and 4 lymphocytes. The platelet count was 150,000. On September 4 the hemoglobin was 10.5 Gm. A chest x-ray on admission showed extensive and large areas of metastatic malignancy in both lungs and in the mediastinum, compatible with metastasis from malignancy of the testicle or hypernephroma. KUB and excretory urograms were interpreted as being normal. An x-ray of the skull was negative. The bone survey, including x-rays of the right arm, left femur, and both lower legs, showed no evidence of metastatic tumor. A repeat chest x-ray on September 2 revealed numerous metastatic lesions in both lung fields, with some slight regression in some of the lesions. However, additional lesions in other portions of the lung were evident at that time. The patient was presented to the Tumor Board, where palliative therapy in the form of nitrogen mustard was recommended. This was followed by a brief subsidence in the severity of the headaches and of the mental symptoms. Terminally, the patient became very lethargic, then lapsed into a coma, and died on September 9.

**Dr. Thomas C. Lipscomb** (Resident in Radiology Service): The first chest x-ray, taken on August 19, showed the areas of metastatic malignancy—round snowball lesions—scattered throughout the lung. After this x-ray, the patient was given nitrogen mustard. The film taken two weeks later demonstrated that there were some areas that had regressed to a certain extent, but there were numerous additional lesions scat-

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tered throughout the lung. Our interpretation at that time was that the origin of the malignancy was either carcinoma of the testicle or of the kidney. These are the two most likely sources that will give that type of metastasis. The pyelograms were normal. The kidney outline was normal. This would fairly well rule out a primary site in the kidney. The only thing that was shown was some increased density throughout the abdomen, which would be compatible with some degree of ascites.

**Dr. Francis B. Landis** (Internist): Although I am fully aware of the morbid delight pathologists, Doctor Lubitz not excepted, experience in confounding clinicians with bizarre, unusual disease entities, the present case appears to depart from that pattern. Perhaps I should be on guard. The problem, as I see it, is to ferret out the primary site of an apparent malignant neoplasm with widespread metastases. On occasion, this can be an exceedingly difficult or impossible task for the clinician, and sometimes the answer is not obtained at the autopsy table. In brief, our diagnostic problem concerns a 27-year-old veteran who succumbed to an illness of 3 months' duration. We can recapitulate and cite the outstanding features; namely, anorexia; increasing fatigue; weight loss of 25 pounds; episodes of chills followed by fever and diaphoresis; and, in late July, headaches, vomiting, blurred vision, and vertigo. Then the patient entered a hospital and had an unsuccessful gastrointestinal series and an intravenous pyelogram, the results of which are not revealed; and a diagnosis of a metastatic malignancy was made. In August he was transferred to Wood. Mental confusion and coma developed, followed by death.

In a young man, ill only 3 months, it is logical to attribute the entire process to a single disease if possible. In older people we should think of more than one disease and complications thereof. The initial picture of a World War II veteran with chills, fever, and sweats suggests the possibility of malaria. A septic process such as a hidden abscess of the brain or lung, perinephritic abscess, or hepatic abscess must also be considered. Other possibilities include Hodgkin's disease, tuberculosis, brucellosis, carcinoma of a parenchymatous organ, or some of the more exotic diseases such as leishmaniasis which may be found in a veteran.

However, in July and August signs and symptoms of increasing intracranial pressure appeared, obviously due to a space-occupying lesion. Now headache, vomiting, blurred vision, choked disk, and vertigo, followed by mental confusion and coma, suggest a primary brain tumor, which may be a glioma. Also, we should think of tuberculoma, abscess of the brain, or a metastatic lesion to the brain. With a brain tumor, two common accompaniments are edema and secondary hydrocephalus. These tend to produce false localizing signs so that the earliest signs which are evident may be the most important. The mental symptoms suggest frontal lobe involvement or multiple metastases to the brain. A very important finding is that of papilledema, or choked disk. In determining increased intracranial pressure, the use of the ophthalmoscope is much more preferable than use of the lumbar puncture needle. With a spinal tap, sudden release of increased pressure may precipitate herniation of the medulla into the foramen magnum or produce acute hemorrhage into a glioma, causing sudden death.

There are other diagnostic tests which might have been done, such as an electroencephalogram or ventriculography to attempt localization of the tumor. Ancillary tests were not done, apparently, because the associated pulmonary metastasis indicated that the cranial lesion was secondary. Brain tumors as a rule remain localized to the cranial vault and do not metastasize peripherally. The cerebral symptoms gave no indication of a primary site of tumor. This is a common sequence in bronchogenic carcinoma, where it is not uncommon for the neurosurgeon to operate for brain tumor and then have the primary lung neoplasm become manifest later. Therefore, in any case of suspected brain tumor, chest x-ray, bronchoscopy, and Papanicolou smears are indicated.

About one third of brain neoplasms are metastatic. The most common sites of the primary tumor are the breast, lung, kidney, skin, colon, and generative organs. It should be remembered that 50 per cent of melanoblastomas will metastasize to the brain. The evidence for a primary site elsewhere in this patient included the appearance of golf-ball lesions in the lungs, interpreted as metastatic carcinoma, and an abdominal mass which, as I have stated, tend to rule out primary tumor in the brain.

I think we should focus our attention on the metastatic lesions to the lungs. Pulmonary metastases may occur by contiguity, by way of the lymphatics, or via the blood stream. Thus the majority of malignant tumors of the body may metastasize to the lungs with varying frequency. Although carcinoma is more common than sarcoma, sarcoma is more likely to involve the lungs in its metastases. Sarcomatous metastasis grows more rapidly and attains a greater size than carcinomatous implants in the lungs. It is unlikely that the large, multiple, round lesions noted on the x-ray are attributable to a primary lung tumor. Occasionally, smaller round lesions in the lung may occur with a primary bronchogenic carcinoma or the alveolar type of tumor. Large, multiple golf-ball or cannon-ball lesions of the lung, varying in size and involving primarily the lower lobes, are almost invariably metastatic. While there is no certain means of correlating the x-ray appearance or type of metastatic lesion to the lung with a definite primary site of tumor, nevertheless, an attempt at such classification is of some diagnostic merit. Cannon-ball, golf-ball, or puff-ball metastases are usually secondary to sarcoma, hypernephroma, or seminoma of the testicle. Of the sarcomas, we could consider osteogenic sarcoma, melanosarcoma, testicular embryonal tumors, lymphosarcoma, and chorionepithelioma. Other types of lung metastasis might be mentioned here. Miliary carcinomatosis of the lungs may occur as a blood-borne metastasis from a primary tumor of the thyroid gland. Another interesting type of metastatic lesion to the lung is the lymphangitic variety. Here the mode of spread is usually to the hilar nodes and then in retrograde fashion along the peribronchial lymphatics to the periphery, where it spreads in a reticular pattern in the subpleural lymphatics. The lymphangitic lung metastasis usually has its primary site in the breast, stomach, pancreas (usually the tail or body), or the prostate gland. This about covers the various metastatic lesions to the lungs.

Now let us turn to the abdominal mass. This may be the crux of the diagnosis. We note that it is non-tender, immovable, and of grapefruit size. I prefer to designate tumor masses in terms of centimeters to follow their progress more accurately. It is not stated whether the mass is superficial or deep. If it were superficial, it might be in the bowel or in the mesentery. If it were deep, it would more likely involve the retroperitoneal lymph node since it does lie in the midline. The thought of Hodgkin's disease comes to mind. We note that the patient had fever, anemia, an abdominal mass, and pulmonary lesions, so it is only natural that I speak briefly of Hodgkin's disease. The pulmonary involvement in Hodgkin's disease may resemble miliary tuberculosis, primary bronchogenic carcinoma, cavitary tuberculosis, or a garden variety metastatic carcinoma to the lungs. The white blood cell count showed a neutrophilia with lymphopenia and thrombocytopenia. These findings suggest Hodgkin's disease but are by no means diagnostic. Myelophthisic anemia, also known as leuko-erythroblastosis, should be considered. This condition is usually due to invasion of the bone marrow, secondary to tumors of the breast, prostate, lung, adrenals, thyroid, stomach, or pancreas. In myelophthisic anemia we see myelocytes, reticulocytes, and normoblasts in the peripheral blood. That was not apparent here. Stippling of red blood cells is mentioned. Stippling may occur in heavy metal poisoning and in various types of anemias. It is seen in some normal individuals also. It is of greater value to know the percentage of red blood cells showing stippling. Militating against the diagnosis of Hodgkin's disease is the intracranial space-occupying lesion. Ordinarily, Hodgkin's disease does not involve the brain.

Another diagnosis we should entertain is that of hypernephroma, otherwise known as adenocarcinoma of the kidneys. Here the mass should be to the right or to the left. Bell states that usually hypernephromas do not show evidence of metastasis unless the primary tumor in the kidney is 5 cm. or more in size.

Other neoplasms to consider are retroperitoneal fibrosarcoma, tumors of aberrant or accessory nerve tissue, neuroblastoma, osteogenic sarcoma, or malignant melanoma. Again we have no obvious primary site to implicate any of these tumors. Skeletal and long bone x-rays were negative.

Finally, we should discuss testicular tumors. While the testicles were apparently normal in this patient, there is statistical evidence which indicates that a primary testicular tumor is a good probability. Vital statistics in Wisconsin for 1951 showed that

*(Continued on page 211)*

# THE MEDICAL FORUM

# COUNCIL PICKS 1954 OFFICERS AT MID-WINTER MEETING

## COUNCIL NAMES COMMITTEES TO SERVE FOR 1954

Milwaukee, Feb. 28.—At its February meeting, the Council of the State Medical Society appointed the members of all council committees, as follows:

*Advertising*: Drs. J. M. Sullivan, Milwaukee; R. S. Baldwin, Marshfield; W. T. Casper, Milwaukee.

*Audit and Budget*: Drs. J. M. Bell, Marinette; A. J. McCarey, Green Bay; E. M. Dessloch, Prairie du Chien; N. J. Wegmann, Milwaukee; J. C. Fox, La Crosse.

*Blood Bank Committee*: Drs. W. D. Stovall, Madison; T. J. Greenwalt, Milwaukee; C. N. Neupert, Madison; Paul Mason, Sheboygan.

*Civil Defense Committee*: Drs. M. J. Musser, Madison, chairman; E. P. Ludwig, Wausau; K. E. Lemmer, Madison; J. S. Wier, Fond du Lac; E. A. Bachhuber, Milwaukee.

*Editorial Board*: Drs. D. W. Ovitt, Milwaukee; Elwood Mason, Milwaukee; Frank Weeks, Ashland; G. A. Cooper, Madison; V. S. Falk, Edgerton.

*Military Medical Service*: Drs. F. L. Weston, Madison, chairman; M. J. Musser, Madison; J. M. Sullivan, Milwaukee; M. H. Steen, Oshkosh; O. G. Moland, Augusta.

*Commission on State Departments*: Drs. T. W. Tormey, Jr. Madison, chairman; H. A. Anderson, Stevens Point; Maxine Bennett, Madison; R. F. Purtell, Milwaukee; R. G. Piaskoski, Wood; J. A. Schindler, Monroe; E. H. Pawsat, Fond du Lac; H. W. Carey, Lancaster; H. A. Sincock, Superior; E. D. Schwade, Milwaukee.

Drs. Anderson and Bennett were first appointed last November to fill unexpired terms.

*Interim Committee*: Drs. J. M. Bell, Marinette; J. C. Fox, La Crosse; R. E. Galasinski, Milwaukee.

*Commission on Prepaid Plans*: Drs. E. M. Dessloch, Prairie du Chien, chairman; Robert Krohn, Black River Falls, vice-chairman; N. A. Hill, Madison; J. T. Sprague, Madison; H. E. Kasten, Beloit; W. T. Casper, Milwaukee; R. E. Garrison, Wisconsin Rapids; K. H. Doege, Marshfield; Milton Finn, Superior; J. S. Supernaw, Madison; H. A. Aageson, Oconto; R. M. Moore, Frederic; C. G Reznichek, Madison; Richard Foregger, Milwaukee; G. W. Carlson, Appleton; P. B. Mason, Sheboygan.

*Veterans Medical Service, Operating Committee*: J. S. Supernaw, Madison, chairman; O. A. Dittmer, Ripon; Maurice Hardgrove, Milwaukee; W. A. Fischer, Frederic; C. E. Koepp, Marinette.

DR. R. G. ARVESON

### *Education Fund Needs Your Help*

Wisconsin physicians are urged to contribute to the American Medical Education Foundation, which raises money to help pay the deficits incurred by the nation's medical schools.

Dr. A. H. Heidner, West Bend, Chairman of the Wisconsin drive, explains that contributions, which are tax-exempt, may be earmarked for any school you desire.

Checks should be made out to the Foundation and mailed to 535 North Dearborn, Chicago 10.

## Approves Television Series Along Lines of "March of Medicine"

Milwaukee, Feb. 28.—To elect officers and approve the 1954 budget and the interim reports, the Council of the State Medical Society met in Milwaukee the last of February.

Dr. R. G. Arveson, Frederic, was elected chairman of the council to succeed himself in office.

Other officers, both of whom were reelected, are Dr. F. L. Weston, Madison, treasurer, and C. H. Crownhart, Madison, secretary. Also reelected were Dr. J. M. Sullivan, Milwaukee, editorial director of the Wisconsin Medical Journal, and Dr. R. S. Baldwin, Marshfield, medical editor of the journal.

### Ready June 1, Hope

The Council formally gave its approval to a recommendation by the Council on Medical Service for the innovation of a society-sponsored television program similar to the March of Medicine on the radio. The proposed programs will be fifteen minutes long, and the first may be kinescoped and ready for production by June 1. They will be developed in cooperation with WHA–TV.

The Council laid down several principles which are to govern this program series. The program format is to be limited to situations typical of the average physician's practice, and actual treatment is to be minimized. All shows will be approved, prior to production, by the State Medical Society.

### Local Permission Necessary

Before showing a kinescope of a WHA–TV production on any station, the approval of the county society where the station is located will be sought. All correspondence resulting from television programs shall be routed through the State Medical Society so that a consistent pattern can be developed for answering inquiries.

*(Continued on page 210)*

# ANTIQUATED GERMAN SYSTEM VICTIMIZES PHYSICIANS

**This is the last half of an article reprinted from "The Bulletin," a weekly survey of German affairs, issued by the Press and Information Office of the German Federal Government. It was submitted to the State Medical Society by Dr. R. G. Arveson, president of the Council.**

**The first portion of the article explained the workings of the German system of compulsory health insurance. A lump sum is paid to each district every three months on the basis of the amount of health insurance paid in that district—not on the number of cases of illness. The doctors who treat patients under this system must divide this lump sum for the payment of their services, no matter how many cases they may have treated.**

The fault lies in the "lump sum" being too small a percentage of the premiums received by public health insurance. The individual insurance agencies cannot be blamed, since they are not privately owned companies but subject to the social security system of the state and have only fixed amounts at their disposal. This system, according to experts, will have to be reformed on the basis of the far greater costs which illness involves today than in Bismarck's time.

### Number Kept Low

As things are now, however, neither the insurance agencies nor the doctors to whom permission has been given to treat "ticket" patients can be interested in making the permission general. The latter must fear that their share in the "lump sum" would then become even smaller; the insurance agencies must fear that they would have to increase the "lump sum" when, instead of three doctors desiring butter on their bread, there would be five doctors with not even bread enough.

**Many observers say there is no remedy for the approximately 30,000 doctors waiting for permission except indeed to wait—with greying hair—until—perhaps—on their 40th or 45th or 50th birthday they may be presented with it.**

Well-meaning friends console them with the prospect of a European army that will need doctors; they do not say how many will be needed. Or they are asked to look forward to the day when, in a reunified Germany, they may fill in the thin ranks of Soviet-Zone physicians. The 30,000, however, cannot live alone on castles in the air.

### Not Too Many MD's

A comparison with conditions in the United States proves that it is erroneous to assume there are too many physicians in Germany. In proportion to the population, the United States has more practicing physicians than Germany and nevertheless one hears of a shortage of doctors.

**No, there are not too many doctors in Germany. Rather, the details of the system of social security are partly outdated. Because of the progress in medical science, a doctor has to give more time to the individual case than he did 50 years ago. Diagnosis has become ever more complicated. And the possibilities of treatment have grown far beyond anything dreamed of at the turn of the century.**

### More Treatment Indicated

Moreover, the 1953 illnesses of humanity are more protracted than formerly, since the average duration of life has been extended by several decades. A patient who formerly might have died in a few days today can often achieve years of life worth living. We accept all this progress as a matter of course, but we tend to forget that it costs more to treat septuagenarians over a period of years than to give a thirty-year-old injections against typhoid. And finally the truism—prevention is better than cure. The wide field of prophylactic medicine has hardly been touched in Germany.

### Reform Needed

Everyone concerned is fully aware that there is need for a reform of the German social security system. And everyone knows of the emergency situation in the rising generation of German doctors. Why, then, one asks, do young people still insist on studying medicine?

Perhaps the attraction is the prestige of an academic profession which still has not lost its aura of freedom and self-sacrifice. It is certain, however, that Germany does not have limited enrollment of the kind that is applied in England. There the number of students admitted to the study of medicine is kept in relation to the number of doctors needed. In Germany, after years of training the graduate may find that his dream of being free to cure and to help his fellow-men has, indeed, been nothing but a dream. The grey-haired doctor still awaiting his chance is a reminder that the reform of our health insurance system and of our medical training is one of the urgent demands of our times. Under-paid, overworked doctors cannot adequately protect the health of a nation.

### Shortage in Soviet Zone

**In the Soviet occupied zone of Germany there is only one medical doctor available for every 2,000 inhabitants, according to a survey published by the Social Democratic Party in Bonn. In the German Federal Republic there are four doctors for every 2,000 inhabitants.**

In the Soviet zone there are altogether 7,248 general practitioners and 3,568 specialists. Following the pattern in other sectors of public life, so-called "doctor-assistants" have been trained since the middle of last year, who work in hospitals and clinics and who are already permitted to carry out operations including even amputations.

### Rise in Sickness

As a direct result of the Communist "health policy" there has been a steady rise in sickness rates, according to the above survey. The figures are kept secret, but the survey claims that in May of this year the number of sick persons in mining amounted to 18.3 percent, in the transport services to 19.3 and in the metallurgical industry to 21.8 percent. A sickness rate of between 2½ and 3½ percent would be considered normal elsewhere.

# FIVE WISCONSIN COUNTIES WILL BE POLIO TEST AREAS

Madison, March 10.—Five Wisconsin Counties have been designated by the National Foundation for Infantile Paralysis as test areas for a polio prevention program which is to take place all over the nation during the next few months.

The counties where the vaccine is to be tried are Milwaukee, Dane, Kenosha, Fond du Lac and Wood.

The vaccine to be used will, it is hoped, provide long-term immunity to polio, unlike gamma globulin which provides only one to five weeks immunity to the disease. Actual length of the immunity produced by the new vaccine is not yet definitely established, but it is hoped the period will be comparable to that provided by smallpox and diphtheria vaccines.

### Plans Are Laid

Health authorities met in Madison December 18 with representatives of the State Medical Society, the State Department of Public Instruction, and the National Foundation for Infantile Paralysis to lay plans for the trial vaccination program.

Local doctors in all areas will need the volunteer assistance of local nurses, health officers, and members of county chapters of the National Foundation, to make the program a success.

### Foundation Gives Vaccine

The National Foundation will provide the trial vaccine without cost to participants. Each second grade student in the designated area will receive three "shots." The first two will be a week apart. The third, or "booster shot," will be given at least four weeks after the second. The results will be checked during the remainder of 1954 against the health records of unvaccinated first and third grade children in the same schools.

The vaccine has been developed by Dr. Jonas E. Salk, Pittsburgh, a March of Dimes grantee. Every batch will be subjected to three rigid, scientific tests for safety before it is used.

The Committe on Blood Banks of the state society met in Madison February 10 to consider a possible change in plans regarding the vaccination program.

An alternative plan would have provided for the vaccinating of the first and third grades as well as the second, but with the use of false vaccination or "placebo" substituted in the shots given to a certain percentage of the children.

The placebo program requires that blood samples be procured from ten percent of the children included.

It was agreed by the committee that the original plan was preferable.

Committee members present at this meeting included Drs. W. D. Stovall and C. N. Neupert, Madison, and Tibor Greenwalt, Milwaukee. Guests were Drs. H. Kent Tenney, W. A. Tanner, C. K. Kincaid, E. H. Jorris and Milton Feig, all of Madison, and Dr. E. R. Krumbiegel, Milwaukee. Russell F. Lewis, assistant state superintendent of schools, was also present.

## Recommend Special Commitment Laws For Disturbed Children

Madison, Feb. 21.—There should be special commitment laws governing children, quite distinct from laws covering disturbed adults, was a conclusion reached by the Subcommittee on the Disturbed Child at its February meeting.

This subcommittee of the Division on Nervous and Mental Diseases of the Commission on State Departments expressed concern that treatment facilities may not be available for the mental cases, particularly those of disturbed children, which will be diagnosed at the new diagnostic center in Madison. It will suggest to the Commission that portions of the new building be utilized for treatment until other treatment centers are available.

It also discussed establishment of short-term treatment centers for disturbed children in cities too small to have permanent ones; further study of the use of present treatment facilities, particularly at Sparta; and establishment of permanent long-term special facilities for children at Mendota and Winnebago.

Committee members present were Drs. Horace K. Tenney, Madison, chairman; Sara Geiger, Milwaukee and L. M. Simonson, Sheboygan.

## Bugbee Named President Of Information Group

New York, Feb. 28.—George Bugbee, executive director of the American Hospital Association for the past eleven years, has been appointed president of the Health Information Foundation. He succeeds the late Admiral W. H. P. Blandy, and will assume his new duties about May 1.

Health Information Foundation is a non-profit organization supported by 165 drug, pharmaceutical, chemical and allied companies. Currently it is engaged in five "fact-finding and public relations projects" dealing with the costs of medical care and health insurance.


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# INDIANA MD'S PRESENT LEAFLET TO AMPLIFY PLAQUES

The following is the text of a leaflet which is distributed by Vanderburgh, Ind., County physicians to their patients, inviting discussion of fees. The pamphlet was written by Dr. W. L. Portteus, Franklin, Ind.

**As Your Physician**—I believe the misunderstandings about the payment of medical bills can be avoided if fees and services are discussed in advance.

It is always my intent to explain fully to each patient—but there may be occasions when I may not fully anticipate the questions which may be foremost in your mind. I hope this pamphlet will assist you in having a better understanding of my services and fees.

**If There Is Doubt**—in any manner in your mind about the charges for your care, please ask me. We will both benefit by a frank discussion, and I want you to feel free to discuss your financial situation with me, if such is your desire.

**My Fees Are Based**—not only on the time spent with you and the nature of your illness, but also upon the time which will be required in making the necessary arrangements for your surgery, and the care required until you are again well and feeling like yourself.

**So You May Understand**—better the cost of your care, and know of the many details involved in preparing for and providing the best care, I ask that you read carefully the following. If you have any questions after you read this pamphlet—please remember, I want you to ask me so a complete understanding may be had.

**Your Care Will Require the Services of a Team**—Surgical treatment requires the services of a team of highly trained specialists—all skilled in their particular responsibility. Not only will I, as your physician, be in attendance, but also a surgeon, an anesthetist, several nurses and in some cases an assisting surgeon.

**Costs vs. Security**—For your security many examinations and tests will be made. Guess work has been removed in giving you the best medical care in the word today. Laboratory tests and X-rays may be needed to determine the reactions of your body and in helping to establish a diagnosis. Also, in case extra blood is required, this too will be on hand for immediate use, and many other security measures which you may not see—for these, there will be charges.

> **This pamphlet was designed to amplify the message on the AMA office Plaques which read "To All My Patients . . . I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between physician and patient."**

**Your Bill**—will in most cases be rendered by the individual members of the team. We shall try and explain as follows—

**The Hospital**—will bill you for the services furnished by the hospital. These usually include your room, board, nursing care, laboratory tests, X-ray, use of operating room (which includes payment for the sterilzation, both prior and following your surgery, of the room, garments, uniforms, linens, instruments, etc.) They will usually bill you for oxygen, drugs and other hospital services administered while you are a patient. (The number of laboratory tests and X-rays will vary according to the type of case and unforseen complications and usually it is not possible to give you an exact estimate on these items.)

**Your Surgeon**—who is highly skilled and well-trained, and who will be in charge of your surgery will bill you for his services.

**The Anesthetist**—who has had special training administering the many modern anesthetics, will charge for his services. The charge which will be shown on your hospital bill for anesthesia is for the materials used and appliances furnished by the hospital and does not include the physician's fee.

**The Assisting Physician**—In most cases of surgery an assisting physician or surgeon is required. While this may seem unnecessary, and added expense—it is for your protection. Added, skilled assistance makes for speedier and safer surgery. You will be billed for this service.

**Your Insurance Plan**—If you have a hospital and surgical insurance plan it should be carefully studied in order that you will know in advance how much of your total bill your insurance will cover. I will be glad to help you prepare an estimate of your total charges as well as how much of these charges your insurance will provide for. I would suggest that you bring your policy with you for this discussion.

**Your Family Physician**—As your family physician, my charges will include: my services rendered prior to your entering the hospital; the calls I will make on you while you are hospitalized, which may be only one or several in a twenty-four hour period; the time and expense of making arrangements for your surgery and hospital admission and for the care required in your illness until you are enjoying a good recovery.

I may be the anesthetist or the assisting physician during your surgery.

**It Is Difficult**—to explain every move and every service which is necessary to provide this care for you and keep it in brief form. I hope you will find this helpful in giving you a better understanding of the services which you will receive and the charges for these services.

Again, I invite you to discuss these matters with me frankly, as it is my desire that you have complete information and understand fully all details in our caring for you.

## Foreign Medical Schools Trained 1,734 Americans In Last Academic Year

Chicago, Jan. 6.—There were 1,734 American students enrolled in 72 foreign medical schools last year, according to the AMA Council on Medical Education and Hospitals.

This figure includes 579 students from Puerto Rico studying in 9 countries.

Of the foreign countries, Switzerland had the largest enrollment of American students—471 of them. Spain was next with 393—386 of whom were Puerto Ricans. Italy was third with 190 and Mexico next with 180.

## Parkin Appears on Postgraduate Education Panel at Licensure Conference in Chicago

Chicago, Feb. 7.— Dr. Robert C. Parkin, Madison, appeared on a panel on postgraduate medical education at the fiftieth annual congress on medical education and licensure held in Chicago in February. Dr. Parkin's panel appearance followed an address by Dr. Douglas D. Vollan of the AMA Council on Medical Education and Hospitals. Dr. Vollan has visited every medical school and medical society in the country, conducting a survey of postgraduate medical education, and his talk was a verbal introduction of his report.

**Following this presentation, there were three panel discussions, one on the objectives of postgraduate education, one on the way to achieve these objectives, and one on facilities, faculty and finance, the requirements of postgraduate programs.**

### Talks on Timing

Dr. Parkin appeared on the second of these, his phase of the subject being the best timing of postgraduate courses. He pointed out the relative merits of the short course arranged on a circuit basis, the three-day short course and those that are held on six successive Tuesdays or other week days.

His conclusion was that each has its place, depending on the size of the community. The small-town physicians and other general practitioners want the short courses. The courses arranged for successive weeks, one evening a week, seem to draw best in large metropolitan centers. Specialists prefer slightly longer and more detailed courses.

**Dr. Parkin is director of postgraduate education at the University of Wisconsin Medical School and medical advisor to the State Medical Society. He is known throughout the state for his society-sponsored health program "The March of Medicine," which is heard weekly on more than forty radio stations.**

According to Dr. Parkin, Dr. Vollan told about television being tried as a means of postgraduate instruction, with unpublicized early morning hours being employed for the telecasts.

The survey showed that more than a third of U. S. physicians are regularly taking advantage of study opportunities. It also showed that responses from about 5,000 doctors surveyed indicate they average 83.3 days a year in keeping themselves up-to-date. This they do by medical reading, professional contacts, hospital staff and medical society meetings, as well as postgraduate courses.

DR. ROBERT C. PARKIN

## Milwaukee Society Health Program Wins TV Award

Milwaukee, March 8.—Beulah Donohue of WTMJ–TV, Milwaukee, was one of seven winners in the third annual McCall's Awards to Women in Radio and Television competition.

Miss Donohue, in cooperation with the Medical Society of Milwaukee county, presented a series of TV programs entitled "Your Family's Health," which appeared on 22 afternoon programs between Nov. 11, 1952 and June 30, 1953.

## Influx of Foreign MD's Regarded as Threat to Medical Care Quality

Chicago, Feb. 9.—A uniform plan for screening the professional competence of foreign-trained physicians was recommended by Dr. Edward L. Turner, Chicago, secretary of the AMA's Council on Medical Education and Hospitals, at the annual congress on medical education and licensure in Chicago.

Dr. Turner said that of 550 foreign medical schools, only a few dozen are formally approved by the AMA. This does not mean disapproval of other schools, but rather lack of information about them.

### Should Be Nation-Wide

He said that "it seems advisable that there should be a careful analysis of state medical practice acts with serious consideration being given to the cooperative development of some commonly acceptable yardstick . . . to evaluate the competence of the foreign graduate."

He suggested that the National Board of Medical Examiners might give an examination to candidates once they had been approved by state boards, in order to decide whether they have had adequate basic training.

He pointed out that "examination for licensure is a powerful instrument through which standards may be maintained and the welfare of the people guarded."

Dr. Willard C. Rappleye, dean of Columbia University's Faculty of Medicine, remarked that unless this situation is met with courage, the whole picture of the high quality of medical care in this country may deteriorate within a few years.

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## VA CAN NOW APPROVE DOCTORS' BILLS BEYOND EXTENT OF ORIGINAL REQUEST

Milwaukee, March 3.—The Veterans Administration has given its Regional Office Chief Medical Officers authority to approve physicians' bills which reflect services different from or more extensive than those originally requested and approved.

This newly anounced policy permits the fee basis physician greater freedom in his treatment of the veteran-patient. Formerly, the physician was restricted to the specific items and amount of service noted on the authorization forms; it was necesary to secure prior approval for change of treatment or additional treatment during the authorized period.

**Now, if because of unforeseen circumstances, the physician is required to deviate from the kind or extent of treatment specified on the Form 200, he may bill for all services as rendered. If the deviation can be approved as medically indicated, the bill can be paid.**

Adequate case reporting is stressed because Veterans Administration's professional reviewers must be satisfied as to the medical reasons for deviations. Dr. S. E. Sebastian, Chief Medical Officer of the Milwaukee Regional Office, emphasized that the physician must be under current authority to treat the veteran for his service connected disability.

Deviations involving treatment of any other condition than that specified on the Form 200 are not allowable.

**It is still necessary to request approval of continuing treatment in advance. Veterans Administration suggests that doctors observe the expiration dates on their Forms 200 and request authority for the next month as far as possible in advance of those dates.**

The doctor should estimate the veteran's treatment needs for the following month and request authority accordingly. However, if circumstances require deviation from the treatment requested, the new policy can be applied. Bills should be complete, since supplemental claims submitted after approval of the original bill cannot be approved under this policy.

## Survey of General Practice Under Health Service Shows Quality of Care Declines

Courtesy of Sheboygan Press

London, Feb. 25.—The lot of the general practitioner under the British health service is not a happy one, according to the report of a committee of the British Medical Association.

This committee took a survey of the work of general practitioners in England today, and the report it released stirred up the following comments:

**From The Times:** "The picture that emerges is that doctors are doing their work conscientiously and competently, with perhaps two in five of a very good medical standard. The picture also has, however, darker tones. The Health Service, which was intended to enlarge the competence of the general practitioner, has in fact enlarged his uncertainty. The least of his troubles is the unreasonable patient who regards him as a servant and not as an adviser. More serious is the committee's complaint that patients generally tend to over-emphasize the place of the hospital in medical treatment. They are often not aware of the capacity of their own doctors to treat quickly most of the common illnesses.

Become Mere Technicians

"The heart will go out of medicine if the general physician is subordinated to the medical technician who is more interested in cases than in people. All through the present century the trend has been that way, and it has been intensified under the National Health Service. Doctors who work in hospitals have been separated from doctors who do not. General consultants are tending to give way to specialists while specialists are becoming more specialized and less willing to deal with the personal doctor on equal terms. So public hospital-mindedness is strengthened, since the general practitioner is given no very evident incentive to good work and many temptations to pass more of his responsibility on to the clinic or to the hospital."

**From the Daily Mail:** "The doctor of today has not the time to think and the freedom to concentrate which is an essential to every professional man. After a crowded session in the surgery he rushes in his car to treat people who are not so much patients as cases to be seen at speed. In many ways, the old family doctor who made a leisurely round in a pony and trap was a better doctor than his successor in a motorcar."

**From the News Chronicle:** "Too many doctors are too busy to examine patients thoroughly and to diagnose ailments carefully enough. Their surgeries are crowded by, among others, those who have trivial complaints and want free treatment for them."

## Exploitation of TV "Heartbreak" Cases Damaging to Medicine

New York, Feb. 7.—The subject of medically needy "heartbreak" cases, especially those that are tearfully pictured before television audiences, was discussed at length at a public relations conference sponsored by the Medical Society of the State of New York recently.

A "heartbreak" case was defined as an appeal for funds through television, radio or press to pay for extensive medical care or an operation, the cost of which is overwhelming to the person involved. The consensus at the meeting was that exploitation of these unfortunate cases must stop.

Seek to Glamorize

Dr. James D. Tyner, Newark, told the conference that investigation of many heartbreak cases showed that patients did not consult with hospital authorities or ask their county medical societies what could be done. "Instead," he declared, "they chose to glamorize their plight.

"The patient must be informed that regardless of ability to pay he need only ask to receive the services of a doctor or hospital care. In these cases, the county medical society, state welfare department and voluntary health organizations are ready to help every deserving person.

"Physicians are already giving service to thousands of potential heartbreak cases in their everyday duties. We must let the people know this fact, and try to prevent the few cases that are dramatized from damaging the good name of American medicine."

# MATCHING PLAN IS SUGGESTED FOR USE OF MEDICAL SCHOOLS AND APPLICANTS

Chicago, March 7.—A matching plan designed to eliminate some of the problems of selecting candidates for admission to medical schools has been proposed by Dr. John A. D. Cooper and Dr. Harold A. Davenport, writing in the October issue of the **Journal of Medical Education.** Dr. Cooper is assistant dean and chairman of the committee on admissions at Northwestern University Medical School, Chicago, Illinois.

### A Mutual Aid

The matching plan is designed to enable both student applicants and medical schools to form mutually satisfactory connections without some of the anxieties and pressures which result currently. Some of the problems are a result of the fact that approximately three times as many students apply as can be admitted to medical schools.

**The projected system is modeled after the highly successful intern-hospital matching plan which has operated for the past three years.**

Under the suggested plan, students would remain free to apply for admission to the school or schools of their choice, and the medical schools would be allowed free indication of preference. All choices, to be filed at the central office of the Association of American Medical Colleges, would be confidential.

### Deadline Needed

As projected, a deadline for applications to all medical schools would be set, possibly for March 1. Some time within the next two months each medical school would send to the central office a list of applicants arranged in order of preference, rejecting any they felt were unqualified for admission by their standards. Students would send the office a list of all medical schools to thich they applied in order of preference. A card for each applicant would then be made by the central office and the matching would be done with complete objectivity, according to the information recorded on the IBM punch cards.

The plan favors the applicant in securing admission to the school of first choice and allows each school to secure the students ranked highest and available to it.

The authors point out that the plan has numerous advantages, not the least being uniform deadline dates for applications. At the present time each school sets its own dates. This creates much uncertainty, sometimes resulting in a student accepting a place in a school with an early deadline, only to withdraw when a later preferred school selects him as a candidate.

DR. E. M. DESSLOCH

# DESSLOCH NAMED DISTRICT HEAD OF BLUE SHIELD

Madison, Feb. 2.—Dr. E. M. Dessloch, Prairie du Chien, has been nominated as District 10 Commissioner of Blue Shield Medical Care Plans, the national trade association of seventy-seven Blue Shield plans in North America.

Dr. Dessloch, chairman of the State Medical Society's Commission on Prepaid Plans, was chosen at a district caucus during a special meeting of Blue Shield Medical Care Plans which took place in Chicago in January. He assumes office at the April meeting in New York.

District 10 includes the states of North and South Dakota, Nebraska, Iowa, Minnesota, Wisconsin and the provinces of Manitoba and Saskatchewan. Both Wisconsin Physicians Service of Madison and Surgical Care of Milwaukee are included in this district's jurisdiction.

# MEDICAL SCHOOL TUITION IS HIGH

Chicago, March 6.—The tuition fees for attending the 72 medical schools and 7 schools of basic medical science during the 1953-54 school year vary from $99 to $968 per year, except in the case of one school which charges $1,291.

The average fee, $633, stands at 164 per cent of the average for 1939–40.

Relatively high as these fees are, they cover only 20.1 per cent of the cost of operating the medical schools.

These figures are from the annual report of the AMA Council on Medical Education and Hospitals. This report shows the average minimum outlay for attending medical school to be $1,682 per year—books and living costs included. The low figure on this list of estimates was $733 per year and the high $3,300.

**Tuition at Marquette University School of Medicine is approximately $850 per year. At the University of Wisconsin Medical School, tuition for Wisconsin residents is $340 per year for the first three years and $250 for the senior year. For out-of-state students, it is $660 for the first three years and $570 for the fourth.**

## To Study Nursing Needs Of Northern Wisconsin

Milwaukee, Feb. 8.—At a meeting in Milwaukee Feb. 7, the Committee on Nursing Education of the Council on Medical Service resolved to make a study of means of solving the nursing needs of the northern part of the state.

Particular attention will be given to the possibility of establishing a school for trained practical nurses at Ashland and assuring the continued operation of the TPN school in Superior.

Committee members who attended this meeting were Drs. J. S. Devitt, Milwaukee, chairman; G. S. Custer, Marshfield; A. H. Heidner, West Bend; G. B. Merline, De Pere; R. C. Parkin, Madison; W. J. Tucker, Ashland, and Mrs. Victor Falk, Edgerton. Guests included Dr. H. Kent Tenney, Madison; Miss Adele Stahl of the State Department of Nurses, Madison, and Dr. A. J. McCarey, Green Bay.

## Coordinating Committee Urges Wider Usage of Chest X-Ray Facilities

Madison, Feb. 12.—The value of the mobile x-ray units in uncovering chest diseases other than tuberculosis, such as lung cancer, was emphasized at the meeting of the Coordinating Committee on Cancer which took place in Milwaukee Feb. 11.

The committee agreed that intensive education programs should be directed toward increased use of the present x-ray facilities and toward the necessity for the patient to go to his physician for further examination if his follow-up card indicates any chest abnormality.

### Schedules Will Be Sent

It was decided that when the mobile x-ray units are scheduled, the schedules should go to the cancer and heart groups so that each can devise specialized publicity campaigns for the age groups with which they are most concerned.

Organizations represented at this meeting were the State Board of Health, the Wisconsin and Milwaukee Divisions of the American Cancer Society, and the Committee on Cancer of the State Medical Society.

Physicians present included Doctors Arthur Van Duser, Milton Feig, W. D. Stovall, all of Madison; James Conley, Milwaukee and R. P. Welbourne, Watertown. Present as special guests were Drs. A. A. Pleyte, Nathan Grossman and Irving Cowan, all of Milwaukee, representing the Wisconsin Anti-Tuberculosis Association, the Wisconsin Heart Association and the Wisconsin Society of Radiologists respectively.

## Wisconsinites Serve on Health Co-op Committee

Two Harbors, Minn., Mar. 19.—A Medical Rights committee, to aid the people of Two Harbors in their law suit against the St. Louis County, Minnesota, Medical Society, has been formed with Charles Bannister, Duluth, as chairman.

Among the members of the committee are Kenneth W. Hones, Chippewa Falls, president of the Wisconsin Farmers Union, and Charles M. Schultz, Milwaukee, president of the Wisconsin Industrial Union Council.

## CONTINUE REVISING COMMITMENT LAWS

Madison, Feb. 17.—Drs. Keith M. Keane, Sheboygan; Michael Kasak, Milwaukee; J. T. Petersik, Winnebago and E. D. Schwade, Milwaukee, were the members of the subcommittee on Commitment Laws which met February 17.

This subcommittee of the Division on Nervous and Mental Diseases of the Commission on State Departments is working on a suggested revision of the laws governing the commitment of mentally disturbed persons. This revision has been undertaken so that such persons will be sent immediately to institutions capable of caring for them, rather than be held several days in jail before being committed.

Drs. Keane and Petersik are to work with some of the local judges to prepare copy for a "Manual on Certification," which will outline for all concerned the responsibilities connected with declaring a person insane and getting him committed to a proper institution.

## Safe Driving Is Form Of Preventive Medicine

Omaha, Feb. 15.—A short course in preventive medicine offered by two Omaha physicians has grown into a Nebraska-wide public service.

Drs. Ralph Moore and Charles Marsh, horrified at the growing rate of traffic deaths, coupled a lecture with graphic illustrations on auto safety, and followed it with a list of do's and don'ts in the emergency handling of injured persons following a highway wreck.

The lecture was first presented to the student body at the University of Nebraska School of Medicine two years ago—has since been repeated about thirty times before youth groups, first aid organizations, police highway patrol and firemen's organizations.

"We pull no punches in our lectures," say the two young doctors. "We show most emphatically the more horrifying aspects of automobile accidents, the better to convince our listeners of the critical need for caution behind the wheel."

## SOCIETY TO PRINT GUIDE FOR CARE OF MIGRANT LABORERS

Madison, Feb. 28.—The Council of the State Medical Society has approved publication by the society of a "Guide for Bettering the Medical Care of Migrant Agricultural Workers."

The outline for such a guide was first approved February 14 by the society's Special Committee on Medical Problems of Migrant Workers. This guide outlines the special problems of communities where migrant labor is needed every summer for picking and processing crops, then suggests a workable plan for holding "sick call" and arranging for doctors to be paid.

It was agreed that for at least the coming season, an intensified program be developed in Door County with the Wisconsin Anti-Tuberculosis Association. Efforts will be made to have movies shown in camps in other parts of the state urging cooperation with the program in Door County, and, if possible, to have the WATA prepare and distribute in camps leaflets in Spanish acquainting workers with the opportunity of having their examinations without cost when they get to Sturgeon Bay.

Committee members who were present were Drs. E. G. Nafziger, Oxford; D. E. Dorchester, Sturgeon Bay; L. W. Schrank, Waupun; E. T. Hougen, Sheboygan; George M. Shinners, Green Bay and Allan Filek, Madison.

## Council Picks Officers . . .

*(Continued from page 203)*

The State Board of Medical Examiners, meeting with the Council at one session, recommended some changes in the Medical Practice Act which will be taken up with the Committee on Public Policy. Dr. J. W. Prentice, Ashland, president of the board, recommended that a committee from the board sit in with the Committee on Public Policy when it is next considering revisions.

E. Harold Hallows, president of the Wisconsin Bar Association, addressed the Council, expressing appreciation for the doctors' part of the recent medicolegal institute in Milwaukee. He suggested that such an institute be made an annual event.

there were 5,388 deaths from cancer, with a death rate of 156.9 per one hundred thousand. That is far above the death rate for tuberculosis, pneumonia, or other allied diseases, with the exception of heart disease, of course. The death rate from cancer is going to increase with ever-increasing groups of older people and fewer people dying of tuberculosis and pneumonia. Testicular tumors comprise only 0.6 per cent of all malignancies in the male. Of significance, however, is that in men between the ages of 29 and 34, tumor of the testicle is the most common neoplasm. Again, in any man between the ages of 20 and 40, the presence of pulmonary metastasis on x-ray is good evidence of a primary tumor in the testicle. Twelve per cent of testicular tumors are found in undescended testicles. That was not present here. Ewing states that all testicular tumors are embryonal carcinomas, arising from tissue with multipotent possibilities of development in the region of the rete testis. They are rapidly growing tumors. The embryonal carcinoma makes up about 60 or 70 per cent of all testicular tumors. They vary greatly in size. The testicle may be ten times normal size, or it may show no enlargement at all, which may have been the case here. The tumors extend by way of the deep lymphatics to periaortic nodes and produce a mass, usually in the region of the renal pedicle. Then they go up the thoracic duct, empty into the superior vena cava, and involve the lung. The left supraclavicular node is often involved. Now we think of that as Virchow's node, typically being palpable in carcinoma of the stomach. Testicular tumor can produce enlargement of this node, as can carcinoma of the lung. Diagnostic tests of value in this case include retrograde pyelograms which, in the presence of testicular tumor with involvement of the retroperitoneal lymph node, will show displacement of the ureter laterally with some rounding of the psoas shadow and a curvature of the spine.

A second important test is the determination of hormone titer in the urine. In testicular tumors, prolan A, the gonadotropic hormone of the anterior pituitary, is increased in quantity and can be measured by the Friedman test or Aschheim–Zondek test qualitatively, or it can be determined quantitatively and then serve as a prognostic test and an indication of metastasis. The response to nitrogen mustard in this case is not unusual. We note that there was diminished headache and a melting away of some of the pulmonary metastasis. This effect is usually short-lived and may be seen in other rapidly growing neoplasms. In conclusion, I think this patient had a tumor with metastasis to the lung and brain with involvement of the retroperitoneal lymph node; the primary site on the basis of statistical evidence would be in the testes. A retroperitoneal sarcoma, arising *in situ,* could not be ruled out.

**Dr. Joseph M. Lubitz** (Pathologist): At the autopsy examination, we found a rather well-developed and still moderately well nourished man, in spite of the tumor. There was a mass found in the skin of the right forearm. Tumor was present throughout the entire body, and I will list where the tumor occurred. There was tumor in the tracheobronchial lymph nodes and in the lung from

Fig. 1—Gross: Scar in left testis.

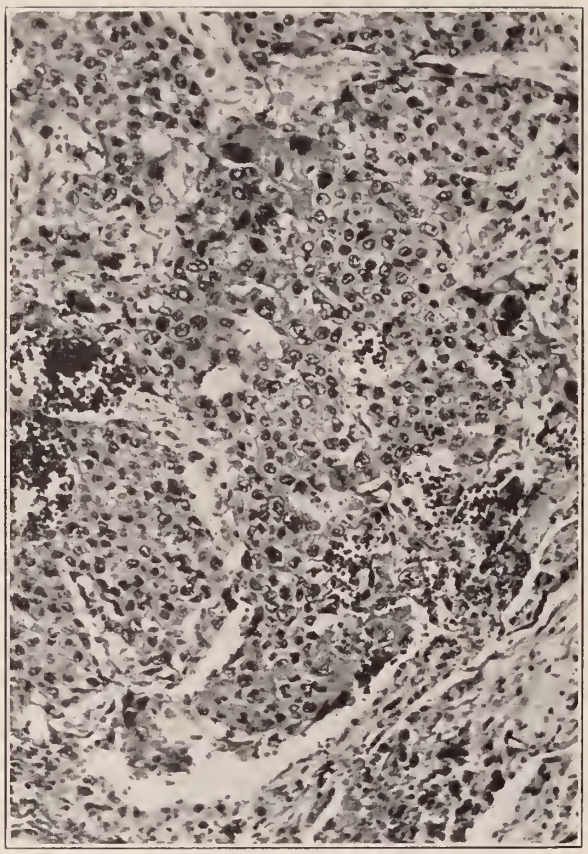

Fig. 2—Lung: Metastatic chorio-epithelioma (Microphotograph, 260X)

1 to 7 cm. in size. The periaortic lymph nodes and omentum showed tumor. The liver was enlarged by tumor and extended about 5 fingerbreadths below the costal margin on the right and about 3 in the midline. The spleen had a tumor 3.5 cm. in size. There was a malignant ulcer in the duodenum, measuring 2.5 cm. In the brain, there were multiple tumor nodes in the right occipital lobe, in the right cerebellum, and in the left parietal lobe, the largest measuring 4 cm. These tumor masses were all uniformly characteristic in appearance. They were soft, hemorrhagic, and grayish-yellow in color. At the autopsy table, there was no primary site determined. The testes were examined, and the only thing found was a small scar about 2 cm. by 1 cm. by 0.5 cm. in the left testicle (Fig. 1). Microscopically, the tumor in the lung was cellular with large, more or less basophilic cells (Fig. 2). Some suggested giant cells, others were syncytial. Hemorrhage was characteristic in most of the slides. The picture is quite characteristic for chorio-epithelioma. In the scar from the testis, there were ghosts of seminiferous tubules (Fig. 3). All was fibrous tissue, but elsewhere interstitial cells were hypoplastic. There was no tumor found in the testis.

**Dr. James W. Sargent** (Attending in Urology): We have here an extremely interesting and rare case, a chorio-epithelioma with no cellular evidence of a primary site in the testicle and no definite evidence of an extra-genital site of origin for a chorio-epithelioma. From the standpoint of testicular tumor alone, this would be a rare case even if it were proved to have originated in the testicle. We know that only one half of 1 per cent of all the malignancies in the male are attributable to testicular tumors, and less than 1 per cent of testicular tumors are pure chorio-epitheliomas.

Concerning the origin of chorio-epitheliomas, it is generally conceded that these come originally from some teratomatous element in the body; and these, of course, are seen most often in the testicle. The testicular teratoma with malignant elements, the so-called teratocarcinoma, often has chorionic epithelial elements in it. This is also true in

Fig. 3—Testis: Scar replacing testicular tissue (Microphotograph, 260X)

the embryonal carcinoma, perhaps more often than in the teratocarcinoma. An embryonal carcinoma is believed by many to be in fact a teratoma with simply an overgrowth of one of the three germ layers, the other two germ layers not being present. There is a second site of origin of chorio-epitheliomatous elements in the male and that is ectopic germinal cells. You remember that in embryologic development, there is a urogenital fold that develops in the early fetus. This fold, as a matter of fact, reaches as high as the level of the sixth thoracic and extends through the length of the body as far down as the second sacral vertebra. As the embryo develops, the fold splits longitudinally into a lateral and somewhat dorsal element that is to become the mesonephros and a medial and somewhat ventral longitudinal fold in which the germ cells are accumulated. Consequently, there is a very distinct possibility of remnants of germinal epithelium persisting in the adult as high as the hilum of the lung. In fact, several instances have been recorded of adult testicular tissue being found at the roots of the mesenteric vessels.

Now, if we are at a loss to find a teratoma or testicular tumor at the basis of the case, we must consider the possibility of an extra-genital chorio-epithelioma, that is, a primary tumor outside of the testis or the ovaries. Perhaps this is not as unusual in the female as it is in the male because we all know of chorio-epitheliomas developing in the extra-ovarian tissues of the female, predominantly, of course, in the uterus following a hydatidiform mole or following retained placental elements which have undergone malignant degeneration. Also, in the female, it is not as uncommon to have an extra-genital teratoma with chorio-epitheliomatous elements in it. In fact, such have been described in the lung, liver, mediastinum, intestine, kidney, and brain in the female.

In the male, however, the situation is not quite that common. As a matter of fact, there are only 9 cases in the entire world literature that have been sufficiently authenticated to represent extra-genital development of a chorio-epithelioma. Interestingly enough, two of these had their origin in the urinary bladder. Two of them developed originally as primary tumors in the mediastinum. Two of them were found in the retroperitoneal tissue, and these two in particular are interesting because in each the site was found to correspond to the original embryologic genital ridge. One of the retroperitoneal tumors had its primary site in the retroperitoneal fat overlying the iliopsoas muscle, and another had its origin behind the kidney. There is one proved case on record of an extra-genital chorio-epithelioma having its origin in the brain in the region of the pineal body. That accounts for 7 of the cases.

The remaining 2 cases I want to discuss in a little more detail because they parallel exactly the case we have today. Both of these cases occurred in young males. Both of them died of chorio-epitheliomas. In neither of them could any possible primary site be found; and of great interest in each one, there was no abnormality in the testicle histologically except for a well-healed scar. There was no other evidence of primary tumor whatsoever. These 2 cases, reported in the German literature, have been classified thus far as being chorio-epitheliomas of extra-genital origin. They are, nevertheless, exact mimics of the case today. This, then, points up the question, "Are we going to classify this case today as a case of true extra-genital chorio-epithelioma, or can we begin to consider the possibility that this case might represent actual spontaneous healing, spontaneous regression of a testicular tumor, with death from diffuse metastasis?"

Whenever anyone mentions spontaneous healing of cancer, we all throw up our hands in horror and say that it is extremely unlikely; and perhaps one would hesitate to say that it ever really has occurred. However, the chorio-epithelioma is of a cellular type which is entirely different from any of the other malignancies we see in the human body. Langhans' cells and syncytial cells have the primary function in the human being of penetrating tissue, particularly of penetrating into blood vessels. It is by this process that the chorionic fronds penetrate the endometrium and into the myometrium to establish a very firm union between the placenta and the uterus that is very intimately associated with the blood supply. So then these cells normally have the ability to penetrate tissue and particularly to seek out blood supplies.

Of interest along this line, we know that grossly these tumors are very hemorrhagic. The chorio-epithelioma, as it metastasizes,

and as we see it in the primary site in the testicle, is characteristically an extremely hemorrhagic tumor. Doctor W. A. D. Anderson, in his textbook, emphasizes the hemorrhagic nature of these tumors and has pointed out how many, many times a large hemorrhagic mass will be found in the testicle, and section after section will have to be cut from this tissue before any viable cells at all can be found. There are many who believe that chorio-epitheliomas heal spontaneously in the female; I think again that this is explained by the peculiar cell type. To repeat once again, we have here a cell type which characteristically produces hemorrhage about it, and it is entirely conceivable that such a hemorrhagic tumor, in the testis for example, could produce so much hemorrhage about it as to utterly bleed itself to death. In other words, by hemorrhage the tumor may isolate itself completely and undergo necrosis; and over a period of time the hemorrhagic area would resolve and leave nothing but a fibrotic scar.

Again of interest and substantiating this possibility is the fact that Doctor Bell and several others have pointed out that chorio-epitheliomas occur in the testicle predominantly in the region of the rete testis. The rete testis, you will recall, is at the upper pole of the testis and the site at which the small tubules, 10 or 15 in number, I believe, leave the testicle and enter the epididymis. It is in this region that chorio-epitheliomas are found most often in the testis. Now again let me remind you of the fact that in each of the cases referred to in the literature in which a scar was found in the testicle, the scar was found in the region of the rete testis. Such is true in the case which we are discussing.

That then sums up the situation. The question remains as to whether this case is to be classified among the 9 cases in the literature of a true extra-genital chorio-epithelioma or whether, even more rare, this case is to be added to the 2 other cases in the entire literature in which it seems extremely plausible and likely, and in fact probable, that a primary chorio-epithelioma developed in the region of the rete testis, underwent spontaneous hemorrhage, spontaneous necrosis and fibrosis, with spontaneous healing of the primary tumor. At the same time remote and diffuse metastasis from the primary site caused the death of the individual. I am inclined to believe that such was the situation in this case.

**Doctor Lubitz:** Doctor Landis, did you say you knew of another instance where regression of tumor occurred in the lung?

**Doctor Landis:** Yes, another case of chorio-epithelioma.

**Doctor Lubitz:** About three years ago at our clinicopathologic conference, we had the presentation of a case of spontaneous regression of a chorio-epithelioma in a uterus, with metastasis to the lung. In this case, the lesions also showed regressive changes, alternating with new growths in the lungs.

**Dr. Roger A. Hemphill** (Chief, TB Service): In the one case you referred to in the uterus, the changes in the lung were primarily due to moving thrombi. I know of two other cases of chorio-epithelioma where metastasis regressed spontaneously. Both women are still alive and having children.

## CHEST FILM ENLARGEMENTS AVAILABLE

The Wisconsin State Board of Health, in response to a suggestion by the Chest Committee of the State Medical Society, announces that it is prepared to furnish, on request by physicians, copies or enlargements of 70 mm. films taken of their patients in mobile unit surveys throughout the state.

In order to expedite such service the State Board of Health will also serve as a clearing house to locate films taken by other agencies which operate independent units.

Physicians desiring such information or films should communicate with:

Division of Tuberculosis Control
Wisconsin State Board of Health
1 West Wilson Street
Madison 2, Wisconsin

# Complications in Anesthesia Related to Cortisone Therapy*

By JOHN W. PENDER, M. D.**
Rochester, Minn.

IN ADDITION to their beneficial effects, most therapeutic agents are capable of causing adverse effects. Cortisone and corticotropin are not exceptions to this general rule. Many of the undesirable effects related to cortisone therapy—intensification of diabetes mellitus, aggravation or development of gastric and duodenal ulcers, and inhibition of resistance to certain infections—have been well publicized. It is the purpose of this paper to call attention to a less well-known complication of cortisone therapy; namely, atrophy and suppression of function of the adrenal cortex so that periods of stress, such as anesthesia and operation, may lead to acute adrenal insufficiency and endanger the life of the patient.

Experimental evidence supports the concept that the administration of exogenous cortisone causes atrophy of the adrenal cortex by suppressing the normal production of corticotropin by the pituitary body. Without stimulation by the corticotropin from the pituitary body, the adrenal cortex ceases to function normally and atrophies. The same sequence of events is thought to explain the atrophy of one adrenal gland in a patient with Cushing's disease when a hyperfunctioning adrenal cortical tumor is present in the opposite adrenal gland.

Since exogenous corticotropin is just as effective as exogenous cortisone in producing hyalinization of the pituitary basophils, it is possible that exogenous corticotropin also may suppress the secretion of endogenous corticotropin and that this suppression may persist for an appreciable period after the administration of corticotropin has been discontinued. To date, however, no case has been reported in which acute adrenal insufficiency followed anesthesia and operation in a patient who had been receiving corticotropin therapy.

Four cases of fatal postoperative adrenal cortical insufficiency have been reported, involving patients who had received prolonged treatment with cortisone before operation and who at necropsy were found to have atrophy of the adrenal cortices. In 1952, Fraser and associates[1] reported on a patient who had received cortisone as treatment for rheumatoid arthritis for 8 months and who died of shock after cup arthroplasty of the hip. At necropsy, bilateral adrenal atrophy was found. In 1953, Salassa and co-workers[2] reviewed the subject of adrenal cortical suppression following therapy with cortisone and reported two postoperative deaths from shock in patients who had been treated preoperatively with cortisone. In the same year, Lewis and associates[3] reported the death of a young woman from adrenal cortical insufficiency precipitated by capsulotomy of a knee for chronic rheumatoid arthritis. She had been receiving cortisone orally for 5 months before the operation. These four deaths are evidence that postoperative adrenal insufficiency of serious magnitude can follow the administration of cortisone. The evidence available at present, however, is not sufficient to permit the answering of many pertinent questions on the subject. Some of the most significant questions will be presented and discussed herein.

What dose of cortisone administered over what period is necessary to produce adrenal cortical suppression? How much time must elapse after cortisone therapy before it is safe to produce anesthesia and perform a surgical procedure? Answers to these questions must be relative, depending on the individual response to the cortisone therapy and the severity of the stress which necessitates increased adrenal cortical activity. Theoretically, any amount of cortisone which is in excess of the daily requirement might suppress the production of corticotropin by the pituitary body. Therefore, a dose of 20 mg. of cortisone per day might be enough to cause adrenal cortical suppression in some patients. On the other hand, most patients who have received relatively large doses of

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**Section of Anesthesiology and Intravenous Therapy, Mayo Clinic and Mayo Foundation.

cortisone preoperatively have withstood the stress of major operations without any symptoms of adrenal insufficiency. On the basis of the present evidence, it is our policy to especially prepare for operation any patient who has received significant amounts of cortisone therapy within 3 to 6 months before the proposed operation.

It is possible that those patients in whom symptoms of hypercortisonism have developed during cortisone therapy are more likely to be subject to adrenal cortical suppression for a longer time after the administration of cortisone has been discontinued than those patients who never exhibited symptoms such as rounding of the face, hypertension, peripheral edema, hirsutism, or fat pads on the back of the neck (buffalo hump) as a result of the medication. Before the performance of any major procedure, it is our practice to prepare with cortisone all patients who have shown symptoms of marked hypercortisonism, unless the patient has had no cortisone for 12 months or longer.

How may the extent of suppression of adrenal cortical function be determined before contemplated anesthesia and operation? Unfortunately, no quick and reliable test or tests are available at present. Such tests as are available, including determination of the urinary excretion of 17-ketosteroids and corticosteroids, the response to the administration of corticotropin, the water test, and the Cutler–Power–Wilder test, measure certain functions of the adrenal glands; but none quantitatively indicate the amount of stress which the individual patient will be able to withstand. Even if a quantitative test were available to measure the capacity of the adrenal glands to compensate for stress, it still would not be possible to estimate objectively the degree of stress imposed by various operations on different individuals.

How may the patient who has recently received significant cortisone therapy be safely prepared for anesthesia and operation? As the result of the experience of members of the Mayo Clinic concerned with metabolism in the preoperative and postoperative care of patients who have Addison's disease or pituitary insufficiency or who have undergone partial or total adrenalectomy, cortisone has been administered intramuscularly before operation and has proved satisfactory as the preparation for surgery of several hundred patients who had been receiving cortisone preoperatively.

Two hundred milligrams of cortisone (100 mg. has been used for small children) is given intramuscularly 48, 24, and 1 or 2 hours before operation to form a depot of cortical hormone for absorption during and immediately after operation. Cortisone administered by mouth is rapidly absorbed, and does not serve as a depot.

Since prolonged fasting and the administration of morphine or its derivatives may adversely affect patients with known adrenal insufficiency, it is possible that these same factors might enhance the stress of operation and anesthesia in patients who have adrenal cortical suppression secondary to the administration of cortisone. The amount of preoperative medication prescribed is about one half that which would be ordered under similar circumstances for a normal patient of the same age and weight. One of the new synthetic analgesic agents such as meperidine hydrochloride usually is ordered in place of an opiate.

How should the anesthesia be conducted? Since patients rarely undergo prolonged anesthesia without the performance of some surgical procedure, it is difficult to know just how much of the stress which results from anesthesia plus operation should be attributed to the anesthesia alone. For the time being, it must be assumed that the anesthesia contributes its share to the adrenal insufficiency which has developed in the patients with adrenal cortical suppression after cortisone therapy. In all four reported deaths, however, the symptoms of adrenal insufficiency began in the postoperative period, when the depth of anesthesia was decreasing. In one case reported by Salassa and associates, the shock did not occur until 15 hours after the operation, when the patient apparently had recovered from the anesthesia.

Little can be concluded about the choice of anesthetic agent or method for this type of patient. Fraser's patient underwent spinal anesthesia with tetracaine supplemented with thiopental sodium intravenously administered. Both Salassa's and Lewis's patients were given thiopental sodium intravenously and nitrous oxide and oxygen by inhalation.

Schwartz and associates[4] reviewed 23 anesthetic procedures carried out for 19 pa-

tients who had Addison's disease. They could demonstrate little relationship between the anesthetic agent employed and the complications which arose. Ether, cyclopropane, thiopental sodium, and local anesthetics were the agents used. Hypotension was encountered with proportionately the same frequency irrespective of which agent was employed. They concluded that patients who have adrenal insufficiency respond to the stress of anesthesia and operation in the same manner as do other patients, but with a considerably more narrow range of compensation. The survival of their patients seemed to depend primarily on good preoperative preparation, since the three deaths in their series occurred among the five patients whose adrenal insufficiency had not been diagnosed prior to operation and who therefore were not especially prepared.

Since being forewarned is equivalent to being forearmed, the anesthesiologist must assume the responsibility of determining, before anesthesia is begun, which patients have received cortisone therapy in the past. Usually, if medication has been used, detailed information about it will be found on the patient's clinical chart; but if such information is not available, the anesthesiologist must make his own inquiry from every patient.

Whether or not a patient has been especially prepared for operation, sudden acute adrenal insufficiency should be considered likely to develop during the operation in any patient who has received cortisone therapy. Preparations of cortisone or hydrocortisone for intravenous use or large amounts of aqueous adrenal cortical extract for intramuscular and intravenous administration should be on hand for such an emergency. Vasopressors, whole blood, and plasma volume expanders should be available to treat shock.

The blood pressure and pulse rate should be taken at frequent intervals so that changes can be detected early and treatment instituted before severe hypotension occurs. Conditions which may result in even minor degrees of tissue anoxia should be avoided, since the tolerance of these patients to adverse circumstances is much less than that of the normal patient. Thorn[5] has especially advised against the use of morphine and tribromoethanol (Avertin) for patients with latent adrenal insufficiency. Other respiratory-depressing drugs should be used with caution unless, and only when, reliable facilities are available for the maintenance of an adequate minute volume of respiration.

What postanesthesia and postoperative care is necessary? Again, the condition of any patient with a history of treatment with cortisone who has undergone an operation should be followed as if adrenal insufficiency were expected because signs and symptoms of adrenal failure are most likely to develop during the first 24 hours after operation. If practical, determinations of blood pressure and pulse rate should be recorded hourly for the first 24 hours, and temperature should be checked frequently. The postoperative fluids for parenteral administration should include a liter of saline or 5 per cent glucose in saline during the first 24 hours. Doses of analgesic and sedative drugs should be relatively small.

Acute adrenal cortical insufficiency occurring during the postoperative period is likely to appear as a sudden fall in blood pressure which is not alleviated by routine measures, by an increase in pulse rate, and perhaps by a rise in temperature and unconsciousness or semiconsciousness. The objectives in treatment of this acute emergency are the administration of adequate quantities of adrenal cortical hormone immediately and the institution of measures to combat shock. An aqueous solution of cortical steroids, such as 100 mg. of hydrocortisone or cortisone dissolved in 500 cc. of saline, may be given intravenously. As an alternative, 50 to 100 cc. of aqueous adrenal cortical extract may be added to the saline being given intravenously. Another 200 mg. of cortisone may be given intramuscularly with the expectation that it will be absorbed gradually and become effective if the shock and collapse can be controlled for the first 24 hours by the more rapidly acting steroid preparations. If the patient is conscious and not nauseated, 100 to 200 mg. of cortisone may be given by mouth for rapid effect and repeated every 4 to 6 hours until the longer-acting cortisone given intramuscularly becomes effective.

For controlling the hypotension, 4 mg. of norepinephrine or 5 to 10 mg. of phenylephrine hydrochloride added to a liter of saline or 5 per cent glucose in saline solution given intravenously usually will give rapid results. Plasma volume may be in-

creased by the intravenous administration of dextran, gelatin, or polyvinyl pyrrolidine. When available, whole blood may be administered to advantage, but care must be exercised not to give too large volumes of fluids parenterally; otherwise, cardiac decompensation might be produced.

### Conclusions

In some patients who have received cortisone therapy prior to anesthesia and operation, acute adrenal cortical insufficiency may develop during the operative or postoperative period. This complication can be prevented by proper preoperative preparation of the patients with cortical hormones.

Mayo Clinic.

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## BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1954 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referral be made by the family physician; but when this is not feasible, arrangements may be made by writing to the Bureau. Forms for the purpose of referral may be obtained from the Bureau of Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify for which clinic forms are wanted.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of the fact.

| | |
|---|---|
| Wausau | March 31, April 1 |
| La Crosse | April 6, 7, 8, 9 |
| Sheboygan | April 13, 14 |
| Superior | April 28, 29 |
| Appleton | May 6, 7 |
| Fond du Lac | May 12, 13 |
| Chippewa Falls | May 20, 21 |
| Rhinelander | June 2, 3 |
| Lancaster | June 10 |
| Darlington | June 11 |

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

# Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

## Questions and Answers Suggested by Recent Investigations in Drug Therapy

*What are the recent developments regarding resistance to antibiotics in staphylococcic infections?* From the Boston City Hospital, Maxwell Finland and Thomas H. Haight[1] report results of tests on 500 strains of hemolytic, coagulase-positive Staphylococcus aureus for sensitivity to nine antibiotics. These strains, isolated from patients under treatment for various infections from October 1951 to February 1952, represented a wide cross section of the staphylococcus population as it appeared in patients entering or under treatment at this hospital. The most striking findings were the great increase in incidence of penicillin-resistant strains and the significant increase over previous findings in the proportion of strains resistant to Aureomycin and terramycin. Only one fourth of the strains were sensitive to penicillin; almost all of the rest were resistant, and only 2.2 per cent were intermediate in sensitivity. About two thirds were sensitive to Aureomycin, almost one fourth were resistant, and 9 per cent were intermediate. Only a little more than half the strains were sensitive to terramycin, nearly one third were resistant, and about 15 per cent were intermediate. Almost all of the strains were intermediate in sensitivity to chloramphenicol. Most strains were intermediate in sensitivity to streptomycin, 20 per cent were sensitive, and 10 per cent were resistant.

Sherris and Florey studied strains of staphylococci from different sources and concluded that penicillin-sensitive strains produce types of lesions different from those produced by penicillin-resistant strains. The sensitive staphylococci were associated with acute and closed lesions and with deep-seated lesions which were either acute or chronic, whereas the penicillin-resistant strains were obtained primarily from superficial infections and were less often associated with signs of inflammation and suppuration. In the present study there was no correlation between the grade of sensitivity of the staphylococci and the source from which they were obtained.

All the Aureomycin-resistant strains were also resistant to penicillin. Essentially the same relation seemed to exist between penicillin and terramycin. The greater proportion of penicillin-resistant strains were either sensitive or intermediate in susceptibility to Aureomycin or terramycin; also, the strains sensitive to Aureomycin or terramycin included about twice as many penicillin-resistant as penicillin-sensitive strains. The correlation between sensitivity and resistance to Aureomycin and to terramycin was very close and might perhaps have been even closer had it not been for the fact that Aureomycin had an appreciably greater inhibitory effect than terramycin on many of the strains. The close relation between Aureomycin and terramycin is consistent with their similar chemical structures.

Previous treatment with antibiotics may be of great importance in establishing strains of staphylococci resistant to the antibiotics used. Some strains are either naturally resistant to one or more antibiotics or acquire such resistance by exposures in other hosts. Although previous antibiotic therapy of any given patient may be an important factor in the occurrence of strains resistant to that antibiotic, the widespread use of antibiotics may be of equal or greater importance in the increase in incidence of staphylococci which are resistant to those antibiotics; such strains may become or remain pathogenic and retain their resistance when they are disseminated and acquired by patients who have themselves not received such antibiotics. This view is supported by the fact that there has been an increase only in the proportion of strains of staphylococci resistant to antibiotics which are widely used and only in places where they are used frequently.

Obviously the use of penicillin in an infection known to be of staphylococcic origin is

ill advised nowadays since penicillin resistance is the rule rather than the exception in such instances. The increase in resistance to Aureomycin and terramycin, as developed in the above sketch of the article of Finland and Haight, is disturbing. However, it is well to bear in mind, as P. H. Long[2] pointed out, that the broad-spectrum antibiotics tend to suppress the penicillinase mechanisms of penicillin-resistant organisms, which may then become penicillin-sensitive after evidencing Aureomycin or terramycin resistance.

Too much reliance should not be placed on routine hospital tests for sensitivity of organisms to antibiotics, for E. A. Bliss[3] showed that such tests may be variously interpreted according to the organism under test, the state of the medium, the method used, and the possible errors in isolation and identification of organisms when the burden of work in the laboratory is great.

*What provides the most concentrated source of Aureomycin excreted into the intestinal tract after parenteral administration?* In searching recently for an answer to this question, Leon R. Cole, at the University of Minnesota,[4] gave 500 mg. doses of the drug to 19 patients. Excretion into the gastric juice was determined in 4 patients with presumably normal stomachs, into the third portion of the duodenum in 8 patients with liver or biliary tract disease and in 1 without, and into the colon in 5 patients with no symptoms referable to the intestinal tract and in 1 with double-barrel transverse colostomy but a normal distal segment.

In general, significant levels of Aureomycin appeared rapidly in the stomach, duodenum, and colon after intravenous injection. The one exception was a patient with complete common bile duct obstruction whose stomach and duodenal contents did not show an active concentration. Even in partial biliary tract obstruction, the duodenal contents exhibited a high concentration of Aureomycin. Bile thus provided the most concentrated source of Aureomycin for excretion into the intestinal tract. Three patients with parenchymal liver damage showed a lag in development of peak Aureomycin levels in the duodenum.

The facts that in subjects with normal intestines Aureomycin appeared in the colon 1½ hours after intravenous injection and that it appeared in the segment distal to a double-barrel transverse colostomy suggest that the drug is secreted along the lower portion of the bowel.—HARRY BECKMAN, M.D.

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## WATA SCHEDULES APRIL MEETING

The annual meeting of the Wisconsin Anti-Tuberculosis Association will be held at the Hotel Pfister, Milwaukee, on Thursday and Friday, April 8 and 9. Dr. David T. Smith, Durham, North Carolina, former president of the National Tuberculosis Association, will deliver the keynote address entitled "Progress Brings Problems," at the 11 a.m. session on Thursday.

Dr. W. D. Stovall, Madison, director of the State Laboratory of Hygiene, will lead a panel discussion on "Unsolved TB Problems" on Thursday afternoon. He will be assisted by Miss Inez L. Davis, public health nurse from Appleton; Dr. Leslie A. Osborn, Madison; and Dr. Jerome L. Marks, Milwaukee.

Friday morning speakers include Dr. Gaylord Anderson, director, School of Public Health, University of Minnesota Medical School, speaking on "The Community's Stake in a Good Health Department," and Drs. Douglas Gutheil, Manitowoc, and R. P. Jahn, Milwaukee, discussing rehabilitation programs.

Governor Walter J. Kohler will be the guest of honor at the Friday luncheon meeting, where he will speak on "Outstanding Wisconsin Health Needs As I See Them."

"What Tuberculosis Does to People" is the topic to be discussed by Dr. F. E. Coburn, University of Iowa Department of Psychiatry, on Friday afternoon; Dr. L. W. Moody, medical director of Pure Air Sanatorium, will speak on "The Sanitorium and the Unknown Case."

# Public Health Nursing Services for Cancer Patients

## As It Looks to Your State Board of Health

THE value of good nursing care for patients with cancer, as for patients with all types of illnesses, is recognized by physicians. The more technical the surgical procedure and prolonged the period of convalescence, the more skilled is the nursing required. Today much of this care has to be given at home because patients are being discharged from hospitals soon after surgery or other treatment. At such times the visiting nurse, city nurse, or county public health nurse can give patient and family invaluable assistance.

Many physicians have hesitated to refer cancer patients to the public health nurse, although most of them automatically refer their tuberculosis cases for follow-up. We are told that one of the significant problems in the cancer control program is follow-up of patients. While this is true of the whole program, in any individual case it is up to the physician in charge to make the decision as to whether the patient should be referred to the public health nurse. This holds true whether the patient is under the care of a private physician or a clinic.

When the decision is made to refer a cancer patient to one of the public health nursing services, the nurse must have specific orders from the physician, must establish a method of reporting to him, and must know what action he wants taken if the patient does not continue treatment. She must know whether the patient has been informed of the diagnosis, and if not, what he has been told. She must know what other household members have been told about the illness.

Hospital nurses have usually taught the cancer patient the technical nursing procedures he will need to use before he goes home. Sometimes this teaching is done with hospital equipment; and when the patient tries to improvise, he runs into difficulties. Such a patient would benefit by a demonstration in his own home.

The public health nurse can assist the patient who has special problems. For example, a woman who has had a mastectomy can be taught how to make simple, normal activities serve as helpful exercises. The nurse can be a morale builder for the patient and her family and can help her in selecting a prosthesis and in returning to normal life.

The colostomy patient usually needs nursing supervision when he returns home from the hospital. He may need assistance with his irrigations or his diet. He may have learned how to do the irrigations in the hospital but may feel insecure when he is left alone to do the procedure. Both he and his family may need guidance in accepting his handicap. The nurse can do much to help him maintain his place as a useful citizen. Hope and courage must be backed up by accurate, practical knowledge that will enable him to go ahead on his own.

Because the public health nurse is constantly working with other agencies in the community and knows their functions, she is able to refer patients who need financial assistance, social welfare or rehabilitation services, etc., to the proper agency.

Another service which public health nurses can offer the physician is that of returning patients for medical care. Nurses can make home visits to patients who do not return to the physician for their checkups. They can find out for the doctor why the patient isn't returning—it may be for psychological or economic reasons; or the patient may feel so well that he doesn't think it is necessary to return. Many times the nurse can persuade the patient to return for medical observation when his family has failed to do so.

To help the public health nurse assume responsibility in cancer control and cancer education, the State Board of Health, cancer societies, and nursing schools conduct in-service cancer education programs. These institutes usually are held in four areas of the state. The last ones were in 1952, when two-day institutes were held in Madison, Eau Claire, Green Bay, and Milwaukee. A two-week cancer workshop for nurses was held at Marquette University last summer, with the State Board of Health being one of the sponsors.

Coordination of services to the cancer patient by physicians, hospitals, and public health nurses should result in better patient care. In turn we can expect better cancer control and higher cancer cure rates—BERNICE BRYNELSON, *Public Health Nursing Consultant in Cancer Control.*

# . . . . THE PRESIDENT'S PAGE . . . .

IN MID-JANUARY the Commission of the national Blue Shield plans held a special meeting in Chicago for the purpose of discussing the interlocking activities of Blue Shield and its nearest relative, Medical Indemnity of America.

This meeting was made necessary, in part, by a strong resolution adopted by the House of Delegates of the American Medical Association at its December meeting in St. Louis. The House decried the sale of radiology, anesthesia, and pathology services in "hospital" contracts in such a way that patients could get no benefits from the plan unless these services were performed by employees of a hospital. The A.M.A. insists that radiology, pathology, anesthesiology, and physiatry are medical services—and rightly so. Furthermore, Medical Indemnity of America seemed to be upsetting Blue Shield plans which embrace the "full payment" concept.

The A.M.A. resolution, in effect, told Medical Indemnity of America to remember the rules of the game as laid down by Blue Shield and the medical profession many years ago and to play the game only in its own back yard. Now such an admonition could form the basis for a bit of a hassle even in the best of families. Therefore, many of us looked forward to the meeting in January with considerable apprehension because we hated to see the philosophies of "full pay" and "indemnity" embroiled in a battle that would do neither of them any good.

However, although there were some sharp disagreements, there was no obvious bitterness; and a set of resolutions was finally adopted which should do much to clarify the whole situation. Our Commission on Prepaid Plans has issued a summary of the meeting. The full report on the deliberations and resolutions has not been completed but will probably be available before long.

One thing about this meeting interested me and is the real reason for this report. It was the feeling I got that a great many men from all parts of the country have a deep conviction that we must not lose the concept of "full payment" for the low income groups. To a "full pay" advocate like myself, this was a stimulating as well as comforting discovery and made the long hours spent at the sessions well worth while, because it seems to me that the concept of "full pay" is one of the most significant contributions made by organized medicine to the vast problem of getting wider and wider distribution of medical services.

Down through the ages, millions of sick people have been cared for by millions of physicians, with no thought of recompense other than that subtle satisfaction which goes with service to one's fellow man and which forms the very foundation and core of our profession. But with the birth, growth, and development of the science of insurance—whereby men pool a portion of their present resources against possible needs of the future—it was only logical that medical needs should be included in the eventualities being budgeted for. This, in theory and in fact, has markedly reduced the amount of so-called "charity work" we are called upon to do. But by utilizing the "service" concept, we preserve a large share of the spirit of our "charity service." For what WPS says, in effect, is this: "O.K., mister, so long as you are earning only so much a year, you can get any of the diseases or conditions on this list and, come hell or high water, we'll take care of you." WPS also says that if the man is earning more than the specified amount, the physician may make an additional charge, thus showing the flexibility of the plan. That is one of the beautiful things about WPS; it is dedicated to the service concept but can also act as indemnity. Both we and our patients gain.

H. Kent Tenney M.D.

# Clinical Results* with Banthine® Bromide

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## 22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

| AUTHORS | No. of Patients | Chronic, Resistant to Other Therapy | TYPES OF ULCERS | | | | RELIEF OF SYMPTOMS (Chiefly Pain) | | | | Surgery or Complications[1] | Side Effects Requiring Discontinuance of Drug[2] | EVIDENCE OF HEALING | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Duodenal | Jejunal | Stomal | Gastric | Good | Fair | Poor | No Report | | | Complete | Moderate | None | No Report |
| Grimson, Lyons, Reeves | 100 | 100 | 93 | 7 | | | 80 | 11 | 4 | | 5 | | 47 | | 19 | 29 |
| Friedman | 15 | 15 | 14 | | | 1 | 5 | | 4 | 6[3] | | | 2 | | | 13 |
| Bechgaard, Nielsen, Bang, Gruelund, Tobiassen | 26 | 26 | 21 | | | 5 | 16 | 4 | 6 | | | | 8 | 6 | 12 | |
| McHardy, Browne, Edwards, Marek, Ward | 162 | | 162 | | | | 136 | 12 | 11 | | 3 | 1 | 14 | 9 | 7 | 129 |
| Segal, Friedman, Watson | 34 | 34 | 34[4] | | | | 14 | 13 | | | 7 | 2 | 5 | | 8 | 14 |
| Brown, Collins | 117 | 99 | 117 | | | | 97 | 7 | 8 | | 5 | 8 | 55 | 9 | 8 | 40 |
| Asher | 77 | | 65 | | 7 | 5 | 52 | 9 | 16 | | | 16 | | 9 | 21 | 47 |
| Rodriguez de la Vega, Reyes Diaz | 5 | 4 | 5 | | | | 4 | | 1 | | | | | 3 | 2 | |
| Winkelstein | 116 | 116 | 102 | 8 | | 6 | 102 | | 14 | | | | 53 | | 18 | 45 |
| Hall, Hornisher, Weeks | 18 | 18 | 18 | | | | 11 | | 1 | 6[5] | | | 18 | | | |
| Maier, Meili | 38 | 38 | 24 | | | 14[6] | 27 | 7 | 4[7] | | | | 10 | 2 | 5 | 21 |
| Meyer, Jarman | 25 | 18 | 25 | | | | 21 | | 4 | | | | | | | 25 |
| Polh, Fromm | 37 | 37 | 37 | | | | 33 | 3 | 1 | | | | 33 | 3 | 1 | |
| Plummer, Burke, Williams | 41 | 41 | 41 | | | | 36 | | 5 | | | | 38 | | 3 | |
| McDonough, O'Neil | 104 | 100 | 104 | | | | 63 | 10 | 31 | | | 11 | 4 | | 11 | 89 |
| Broders | 60 | 60 | 58 | | 1 | 1 | 35 | 19 | 6 | | | | 10 | 1 | 49[8] | |
| Legerton, Texter, Ruffin | 11 | | 11 | | | | 11 | | | | | | | | | 11 |
| Holoubek, Holoubek, Langford | 76 | 69 | 76 | | | | 35 | 27 | 10 | | 4 | 10 | 26 | | 10 | 36 |
| Ogborn | 42 | | 39 | 2 | | 1 | 42[9] | | | | | | | | | 42 |
| Shaiken | 48 | 48 | 48 | | | | 33 | 10 | 3 | | 2 | | 33 | 10 | 3 | |
| Johnston | 145 | 145 | 145 | | | | 143 | | 2 | | | 2 | 143 | | 2 | |
| Rossell, Knox, Stephenson | 146 | | 141 | | | 5 | 146 | | | | | 4[10] | 53 | | | 93 |
| TOTALS | *1443* | *968* | *1380* | *17* | *8* | *38* | *1142* | *132* | *131* | *12* | *26* | *54* | *552* | *52* | *179* | *634* |
| PERCENTAGES | | 67.8 | 95.6 | 1.2 | 0.6 | 2.6 | 81.3 | 9.4 | 9.3 | | | 3.7 | 70.5 | 6.6 | 22.9 | |

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

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# « « « EDITORIAL » » »

## No Recession for Medicine

The bumper baby crop of 4 million in 1953, the highest ever, continuing the high plateau which has been present for fourteen years and which seems to show no inclination for its slacking off, together with the ever increasing span in life, will certainly increase the demand for physicians for years to come. The elementary schools, high schools, and universities are jammed to overflowing now and pose problems of critical teacher shortages.

From the physicians' viewpoint, the health needs of this expanding population will continue to mount. Medicine and all ancillary professions will find shortages in personnel as the need increases. Technological advances in industry have cut down the number of workers needed as far as production is concerned. However, workers needed in the so-called services, including the professions, will increase.

With families increasing in size and incomes being high, there has been a tremendous exodus from the center of cities to the suburbs while the cities have remained stagnant. Therefore, doctors' offices and practices will more and more be located in the rapidly growing suburbs.

If you are planning to move to another state, the best states for both growth and income are Colorado, Nevada, Oregon, Washington, Maryland, Michigan, Delaware, Connecticut, and Ohio. Some of those with poor growth and low income are Mississippi, Arkansas, and Alabama. Wisconsin's average income is medium and its rate of growth is 16 per cent, with 18 per cent being about the average. The United States population is now 161 million; expected in 1960, 168 million; 1990, 250 million. Wonder where they will hold the A. M. A. convention in 1990.

## The Red on the Journal

Those readers without achromatopsia will note a change in the color on the cover of the *Journal*. It might be attributed to a dose of premature spring fever and a temptation to kick up our heels and flout tradition. But the truth is that it's an attempt to get "out of the red" into a lesser shade of color (and financial cost). To provide as much money as possible for quality of production for scientific articles and the popular "Medical Forum," we've trimmed our financial sails wherever possible. So from now on, when you see the present red-covered publication in your office, you will know it's the *Medical Journal*, dressed up in a new shade of red carefully selected at the bargain counter. We hope you like it and that you understand the reason for the change.

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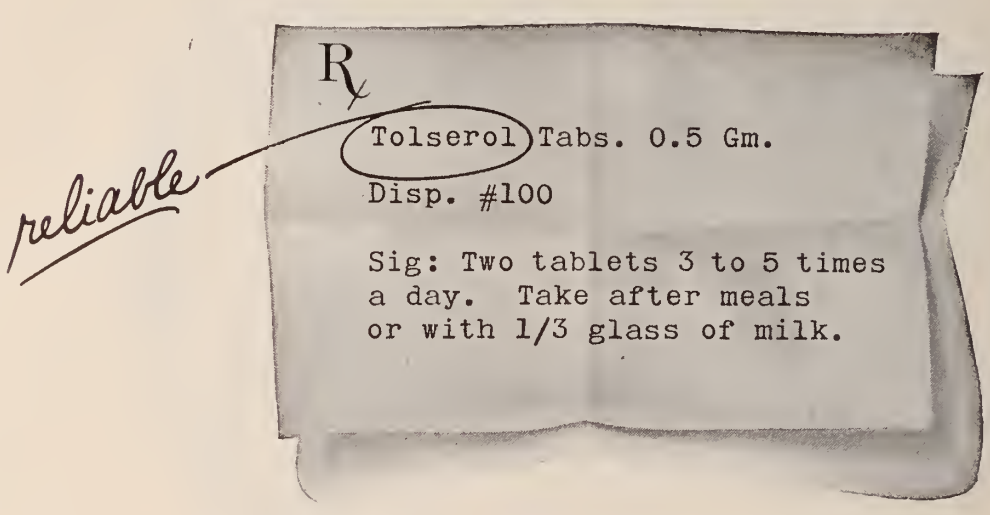


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# Reminder:—On Circuit Teaching Programs

If you have not already done so, sign up for the circuit teaching programs listed below which are nearest your home. Registration, $6.00, including dinner. (For the Upper Peninsula two-day session, registration fee for both days is $7.50, plus cost of dinners).

## April

RELATED DISEASES OF THE CHEST

| April 13 | April 14 | April 15 |
|---|---|---|
| Eau Claire | Stevens Point | Appleton |

RADIOLOGIC ASPECTS OF DIFFERENTIAL DIAGNOSIS OF PULMONARY DISEASE: John L. Armbruster, M.D., Milwaukee

COMMON FUNGUS DISEASES OF THE CHEST: Helen A. Dickie, M.D., Madison

SELECTION OF PATIENTS WHO MIGHT BE BENEFITED BY SOME FORM OF CARDIAC SURGERY: Thomas J. Dry, M.D., Rochester, Minnesota

SUPPURATIVE DISEASES OF THE CHEST: John D. Steele, M.D., Milwaukee

## April

| April 27 | April 28 | April 29 |
|---|---|---|
| Platteville | Oconomowoc | Manitowoc |

MATERNAL MORTALITY FINDINGS AND CONCLUSIONS IN RELATION TO MEDICAL PRACTICE IN WISCONSIN: F. J. Hofmeister, M.D., Milwaukee

INFANT AND CHILD NUTRITION: Robert L. Jackson, M.D., Iowa City

DIABETIC EMERGENCIES: Howard F. Root, M.D., Boston

FRACTURES OF THE ANKLE: Herman W. Wirka, M.D., Madison

## May

| May 25 | May 26 | May 27 |
|---|---|---|
| Chippewa Falls | Pinecrest (Iron River) | Rhinelander |

TREATMENT OF COMMON SKIN LESIONS: Garrett A. Cooper, M.D., Madison

ENDOCRINE THERAPY IN GYNECOLOGIC DISORDERS IN RELATION TO CANCER: Edwin J. DeCosta, M.D., Chicago

MODERN MANAGEMENT OF HYPERTENSION: Henry A. Schroeder, M.D., St. Louis

A REVIEW OF NEUROLOGICAL SURGERY: Henry Schwartz, M.D., St. Louis

## June

| June 16 | June 17 | June 18 |
|---|---|---|
| Racine | Elkhart Lake | Menominee, Mich. |

CURRENT THERAPY IN THE TREATMENT OF TOXEMIAS: Allan C. Barnes, M.D., Cleveland

DIAGNOSIS AND TREATMENT OF LIVER DISEASE: Richard B. Capps, M.D., Chicago

MEETING PROBLEMS OF PREMATURITY IN GENERAL PRACTICE: James P. Conway, M.D., Milwaukee

WHAT SURGERY HAS TO OFFER IN PULMONARY DISEASE: Joseph W. Gale, M.D., Madison

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## Registration Blank

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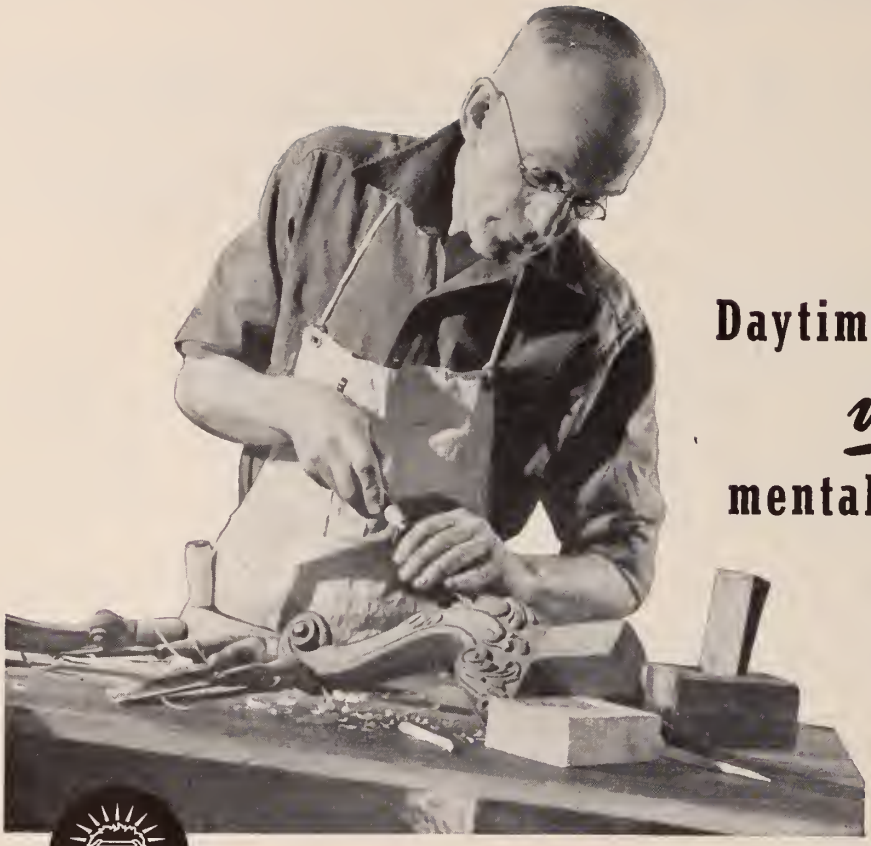
CHECK THE CLINICS YOU WILL ATTEND: $6.00 per clinic except for Menominee, Michigan. (If you will attend two-day session, the charge will be $7.50).

April 13: Eau Claire ____
April 14: Stevens Point ____
April 15: Appleton ____
April 27: Platteville ____
April 28: Oconomowoc ____
April 29: Manitowoc ____
May 25: Chippewa Falls ____
May 26: Pinecrest ____
May 27: Rhinelander ____
June 16: Racine ____
June 17: Elkhart Lake ____
June 18: Menominee, Michigan ____



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# Society Proceedings

## Brown–Kewaunee–Door

A regular meeting of the Brown–Kewaunee–Door Counties Medical Society was held at the Elks Club in Green Bay on January 14. Members of the society heard *Dr. Meyer S. Fox*, Milwaukee, discuss "Industrial Noise and Hearing Loss." A seven o'clock dinner preceded the meeting.

At the February 11 dinner meeting, *Dr. Amy Louise Hunter*, director of the Bureau of Maternal and Child Health of the State Board of Health, Madison, discussed the current maternal mortality study and the proposed fetal-neonatal death study, which are projects of the Committee on Maternal and Child Welfare of the State Medical Society.

## Dodge

The annual Christmas dinner meeting of the Dodge County Medical Society was held at the Elks Club in Beaver Dam on December 12. A large group of members and their wives heard talks by Dr. Flavio Puletti of Florence, Italy, Doctor Thorarinson of Iceland, and *Dr. Anthony Curreri* of Madison.

Drs. Thorarinson and Puletti are resident physicians at the Wisconsin General Hospital, Madison. They spoke of first impressions upon entering the United States and encountering the customs of our people. Doctor Curreri spoke of his trip to Spain, Portugal, and other southern European countries.

## Douglas

Twenty-one members of the Douglas County Medical Society heard Doctor Fuller and Doctor Thomas speak on a film by Winthrop–Stearns entitled "Regional Anaesthesia" at a business and scientific meeting held on February 3. The meeting was held at the Hotel Superior.

## Fond du Lac

The annual Christmas outing of the members of the Fond du Lac County Medical Society was held on December 17 at the South Hills Country Club, Fond du Lac.

On January 28, 35 members met at the Elks Club to hear *Dr. Keith M. Keane*, Sheboygan, discuss "Early Treatment of the Anxious and Depressed Patient."

The society elected *Dr. N. O. Becker* as representative of the local chapter of the American Cancer Society. The blood procurement committee of the American Red Cross reported to the society about its successful bloodmobile visit, with 288 pints donated in two days.

## Kenosha

The Elks Club, Kenosha, was the meeting place of 42 members of the Kenosha County Medical Society on January 8. The meeting was devoted to committee reports and a discussion of Willowbrook Sanatorium and the Orthopedic School. A committee was appointed to make further study of these institutions.

On February 4 the society heard Dr. Walter Priest, associate professor, Northwestern University Medical School, and chairman of the section on cardiology, Wesley Memorial Hospital, Chicago, discuss "Diagnosis and Selection of Patients for Cardiac Surgery." Dr. Edward E. Avery, a member of the surgical staff of Northwestern University Medical School and Wesley Memorial Hospital, Chicago, spoke on the "Surgical Aspect of Congenital and Acquired Heart Disease." He used motion pictures and slides to illustrate his lecture.

## Langlade

Members of the Langlade County Medical Society and of the Woman's Auxiliary to the society met January 27 at the Antigo Country Club to hear an explanation of the State Medical Society's radio program, "The March of Medicine." The director of the program, *Dr. Robert C. Parkin*, of Madison, was the speaker.

## Marinette–Florence

Members of the Marinette–Florence Counties Medical Society met on January 20, at which time the following officers were elected:

President—*Dr. Kenneth Moss*
Vice-President—*Dr. Phillip R. McCanna*
Secretary—*Dr. Raymond Rogers*
Delegate—*Dr. Charles Koepp*

All of the officers are from Marinette.

## Polk

*Dr. Lorne A. Campbell, Jr.* was host to sixteen members of the Polk County Medical Society on January 20 for a dinner meeting at Paradise Lodge, Balsam Lake.

Members of the society heard Dr. Donald Lannin, St. Paul, Minnesota, lead a round-table discussion on "The Orthopedic Problem of Low Back Pain." *Dr. William Fischer*, Frederic, was appointed to represent the society on the county committee to study the care of the aged.

## Richland

Guest speaker at the January 12 meeting of the Richland County Medical Society at the home of *Dr. K. H. Meyer*, Richland Center, was Mr. Roy Ragatz, assistant secretary of the State Medical So-

ciety. Mr. Ragatz discussed "Are We As Bad As the Public Thinks We Are?"

Mr. Paul Doege, sales co-ordinator, Wisconsin Physicians Service, discussed the Blue Shield insurance program.

### Winnebago

A regular meeting of the Winnebago County Medical Society was held on January 7 at the Menasha Hotel, Menasha. The speaker of the evening was *Dr. Paul G. LaBissoniere*, Milwaukee, who spoke on the topic, "Heart Disease Amenable to Surgery."

*Dr. John L. Sims*, professor of physical diagnosis, University of Wisconsin Medical School, spoke at the meeting of the society held on February 4 at the Hotel Athearn, Oshkosh. Doctor Sims spoke on "Aspects of Liver Diseases."

### Wood

New officers elected at the Wood County Medical Society meeting held on January 21 at the Hotel Mead, Wisconsin Rapids, are:

President—*Dr. H. G. Pomainville*, Wisconsin Rapids

Vice-President—*Dr. G. L. McCormick*, Marshfield

Secretary—*Dr. N. J. Helland*, Marshfield

Delegate—*Dr. R. W. Mason*, Marshfield

Alternate Delegate—*Dr. W. L. Nelson*, Wisconsin Rapids

"Urolithiasis" was the topic presented by Dr. T. H. McDonell, Marshfield; and *Dr. A. J. Macht*, Marshfield, presented a paper entitled "Differential Diagnosis in Psychiatry."

### Wisconsin Heart Association

Two nationally prominent heart specialists conducted a clinic on "The Problems in Clinical Cardiology" Thursday, December 3, at the Service Memorial Institute, Madison.

Dr. Johnson McGuire, Cincinnati, gave a lecture entitled "The Diagnosis and Treatment of Acute Pericarditis." Dr. Charles P. Bailey, Hahnemann Hospital and Bailey Thoracic Clinic, Philadelphia, talked on the subject, "Surgery for Rheumatic Valvular Disease."

# News Items and Personals

### Doctor Gmeiner Speaks in Clintonville

*Dr. James E. Gmeiner*, Appleton, was the principal speaker at a banquet for the staff and board of directors of the Clintonville Community Hospital held on February 2. The banquet was held at the Marson Hotel, Clintonville.

### Dr. James Pinney to Practice in Green Bay

*Dr. James C. Pinney* has opened an office for the general practice of medicine in Green Bay. Born in Argyle, Wisconsin, he moved to Kansas at an early age and attended school there. After receiving his medical degree from the University of Kansas School of Medicine in 1942, he served at the U. S. Naval Hospital, Great Lakes, Illinois, for a year and then entered private practice in Chicago and taught at Northwestern University. He was commissioned a first lieutenant in the Army Medical Department and served for two years, being discharged in 1946 as a captain.

He entered private practice at Sturgeon Bay and remained there until last July, when he left to engage in travel and postgraduate study until opening his office in Green Bay.

### Doctor German Speaks to Hospital Groups

*Dr. John D. German*, Clintonville, spoke at a meeting of nurses and administrators of Clintonville and New London hospitals on November 11 at the Clintonville Hospital. The topic of his talk was "Cancer."

The meeting was part of the maternal and child health program of the New London and Clintonville area.

### Vernon Memorial Hospital Staff Changes

*Dr. Edward Vig*, Viroqua, was elected chief of staff of the Vernon Memorial Hospital at a staff meeting held Thursday, January 21. *Dr. Harold E. Oppert* was elected vice chief of staff, and *Dr. DeVerne Vig* was re-elected secretary-treasurer.

Dr. Edward Vig succeeds *Dr. Carl Ender* as chief.

### Grantsburg to Get New Physician

*Dr. Harry H. Larson*, an associate of the Northland Clinic in Rice Lake, has announced that he will establish a private practice at Grantsburg in the near future. Doctor Larson received his medical degree from the University of Wisconsin in 1952 and interned at St. Luke's Hospital in Duluth.

The city of Grantsburg has been without the service of a resident physician for nearly two years; and the Grantsburg Hospital, which closed several months ago because services of a physician were unavailable, plans to resume operation in the near future.

### New Physician in Watertown

*Dr. Claude W. Schmidt*, formerly of Gresham, Shawano County, has opened a practice in Watertown. Doctor Schmidt was graduated from the University of Wisconsin Medical School in June 1949 and interned at the University of Kansas, Kansas City. Prior to entering the Navy in October 1950, he was in charge of practices at Waterford and Mayville. He was discharged from service as a lieutenant last October.

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| 30 days of Nurse at Home | 5.00 per day | 10.00 per day | 15.00 per day | 20.00 per day |
| Laboratory Fees in Hospital | 5.00 | 10.00 | 15.00 | 20.00 |
| Operating Room in Hospital | 10.00 | 20.00 | 30.00 | 40.00 |
| Anesthetic in Hospital | 10.00 | 20.00 | 30.00 | 40.00 |
| X-Ray in Hospital | 10.00 | 20.00 | 30.00 | 40.00 |
| Medicines in Hospital | 10.00 | 20.00 | 30.00 | 40.00 |
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| COSTS (Quarterly) | | | | |
| Adult | 2.50 | 5.00 | 7.50 | 10.00 |
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## Doctor Hildebrand Meets with Governmental Officials

*Dr. William B. Hildebrand*, Menasha, represented the American Academy of General Practice, of which he is president-elect, at a recent session of Governmental officials in Washington, D. C., where the health policies of the Republican administration were explained. Representatives of the American Medical Association, the American Bar Association, the American Dental Association, and the American Association of Voluntary Insurance Companies were also present at the meeting.

Doctor Hildebrand addressed the Menasha Rotary Club upon his return.

## Dr. Max Smith Speaks in Wausau

"Emotional Disturbances Among the Aged" was the subject discussed by *Dr. Max H. Smith*, Madison, a member of the Mendota State Hospital staff, in a lecture at Wausau on November 12. This was the fourth in a series of seven talks in a mental hygiene lecture series sponsored by the University Extension Center in Wausau.

A 1944 graduate of the University of Wisconsin Medical School, Doctor Smith has held his present position as resident psychiatrist on the staff of the Mendota Hospital since 1950.

## Wisconsin Physicians Attend American College of Physicians Meeting

Twenty-two physicians presented scientific papers at the Midwest regional meeting of the American College of Physicians held on November 21 at the Hotel Schroeder, Milwaukee. About 600 doctors from Wisconsin, Illinois, Indiana, Iowa, and Minnesota attended the meeting. Besides the scientific program, the session included a luncheon and a dinner-dance at the hotel. *Dr. Francis D. Murphy*, Milwaukee, was general chairman of the meeting, while *Dr. J. W. Rastetter*, also of Milwaukee, was chairman of arrangements.

## Doctor Anderson Joins Staff of Grandview Clinic

*Dr. Paul Anderson* has returned after three years of training in eye disease and eye surgery to join the Grandview Clinic and Hospital staff in La Crosse. After graduation from Marquette University School of Medicine in 1942, Doctor Anderson spent three years in the Army and then practiced for five years in La Crosse. After leaving La Crosse, Doctor Anderson spent one year at the Gill Memorial Eye, Ear, Nose, and Throat Hospital in Roanoke, Virginia; 18 months in surgical work at the Milwaukee County Hospital and Marquette University; and six months at Milwaukee Children's Hospital.

### New Physician in Hartland

*Dr. James R. Howlett,* a native of Texarkana, Arkansas, officially opened his office at Hartland on November 2 for the general practice of medicine and surgery. He was graduated from the University of Arkansas School of Medicine in 1946 and served his internship at Baylor University Hospital in Dallas, Texas. He entered the armed forces in 1950 and served 33½ months overseas in Okinawa as a regimental surgeon of the 29th Regimental Combat Team. He returned from overseas in August 1953 and was recently discharged from the service.

### Dr. V. V. Quandt Heads Hospital Staff

*Dr. V. V. Quandt* was elected president of the St. Joseph's Hospital staff at Hartford in early January. Other officers elected were *Dr. James E. Albrecht,* Jackson, vice president, and *Dr. Theodore J. Kern,* Richfield, secretary-treasurer.

*Dr. John Sinsky* of Milwaukee talked on "Operative Procedures in Obstetrics" at the staff meeting.

### Staff Elections Held at Waupun and Beaver Dam Hospitals

*Dr. D. P. Cupery* has been elected chief of staff of the Waupun Memorial Hospital, Waupun, and the Lutheran Deaconess Hospital, Beaver Dam.

*Dr. W. J. Petters,* Waupun, was elected secretary of the Waupun hospital staff; and *Dr. R. A. Knudson,* Horicon, was named secretary at the Lutheran Hospital, Beaver Dam.

## THIRD AND TWELFTH DISTRICTS NEWS

### Doctor Cooper Speaks to Physical Therapists

*Dr. G. A. Cooper,* Madison, discussed "Dermatological Lesions Encountered by the Physical Therapist" at a meeting of the Wisconsin Chapter of the American Physical Therapy Association held on January 23. The meeting was held at Madison General Hospital, Madison.

### Wisconsin Academy of General Practice, Madison Area Chapter

The Madison area chapter of the Wisconsin Academy of General Practice held its annual meeting on January 7 at the Park Hotel, Madison. In elections held, *Dr. John Van Gemert,* Madison, was elected president; *Dr. Samuel Sorkin,* Evansville, president-elect; *Dr. M. T. Morrison,* Mt. Horeb, secretary; and *Dr. Louis Fauerbach,* Madison, treasurer.

Delegates elected to the state conference in November were *Dr. R. J. Hennen,* Madison, and *Dr. V. W. Nordholm,* Stoughton; alternates are *Dr.*

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The organization, which is composed of 40 general practice physicians in the Madison area, heard *Dr. Peter Golden* of Madison speak on orthopedics.

## Dane

The January meeting of the Dane County Medical Society was held at the Madison Club, Madison, on January 12. *Dr. Frank Bernard*, Madison, spoke on "The Differential Diagnosis of Oral Lesions" and supplemented his speech with slides.

On February 9 the society met at the Blackhawk Country Club, Madison. Guest speaker at the smörgåsbord dinner was Ivan B. Williamson, head football coach at the University of Wisconsin. There were about 130 members present at the meeting.

## Sauk

"Presentation of Recurrence of Inguinal Hernia" was the title of a paper presented by *Dr. William P. Young*, associate clinical professor of surgery, University of Wisconsin Medical School, at the January 12 meeting of the Sauk County Medical Society held at the Warren Hotel, Baraboo. Fourteen members of the society participated in the discussion.

A dinner meeting was held on February 9, at which Earl R. Thayer, director of public information of the State Medical Society, talked on "Facts and Fables about the Medical Society." The meeting was held at the Warren Hotel, Baraboo.

## Rock

The Rock County Medical Society held a dinner meeting on January 26 at the Hotel Hilton, Beloit, and heard *Dr. Raymond Welbourne*, Watertown, chairman of the State Medical Society Committee on Cancer. Doctor Welbourne showed a film on cancer during the program following the dinner.

## Doctor Okagaki Speaks in Beloit

*Dr. Henry Okagaki*, Madison, spoke before interested Beloit citizens on November 3 about the need for a treatment center for cerebral palsy patients in the city. Doctor Okagaki is medical director of the Easter Seal cerebral palsy center and is a member of the staff of the Wisconsin Orthopedic Hospital, Madison.

Also attending the meeting was *Dr. W. J. Ganser*, Madison, a member of the Wisconsin Elks crippled children's commission.

## Janesville Physicians Speak to Rotarians

Janesville Rotarians heard several doctors discuss the trends toward specialization in the medical field at their November 30 meeting. Doctors who spoke were *M. B. Llewellyn, E. W. Reinardy, S. A. Freitag, H. M. Snodgrass, P. K. Odland, O. V. Overton*, and *W. T. Clark*.

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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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## Beloit Hospital Staff Has New Head

*Dr. R. M. Baldwin*, Beloit, has been elected president of the Beloit Hospital medical staff, succeeding *Dr. R. H. Gunderson*, who was appointed to the executive committee. Dr. Baldwin was former medical director at the Janesville General Motors plants.

## Milwaukee Academy of Medicine

Dr. Edward H. Rynearson spoke on the topic, "Clinical Disturbances of the Endocrine Glands," at the December 15 meeting of the Milwaukee Academy of Medicine. Doctor Rynearson is consultant in the Division of Medicine, Mayo Clinic, and professor of medicine, Mayo Foundation Graduate School, Rochester, Minnesota.

*Dr. Joseph F. Kuzma*, professor and director of the Department of Pathology of the Marquette University School of Medicine, was named president-elect of the Academy on January 19 at the annual meeting at the University Club.

Others elected by the Academy were *Drs. Maurice Hardgrove*, vice-president; *John Charles*, secretary; *Morrison Schroeder*, treasurer; *Howard J. Lee*, librarian; *Francis F. Rosenbaum*, curator of the Brown collection; and *Donald Willson*, member of the membership committee.

Elected to the council were *Drs. Harry Beckman, Lamont Schweiger, James E. Conley, Albert Schmidt, Albert G. Martin*, and *S. A. Morton.*

*Dr. Arthur A. Holbrook* took office as president of the Academy, succeeding *Dr. Albert C. Schmidt.* Sixteen new members were initiated into the organization.

At the February 16 meeting Dr. Mark D. Altschule, director of internal medicine and research in clinical physiology, McLean Hospital, Waverly, Massachusetts, and assistant professor of medicine, Harvard Medical School, spoke on the subject of "Physiologic Observations in Mental Disorders."

## Milwaukee Neuro-Psychiatric Society

The January 20 meeting of the Milwaukee Neuro-Psychiatric Society was held at the University Club, Milwaukee. Members heard Dr. J. Grafton Love, consultant in neurosurgery at the Mayo Clinic, Rochester, Minnesota, and professor of neurosurgery at the University of Minnesota, speak on "The Diagnosis and Treatment of Trigeminal and Glossopharyngeal Neuralgia."

## Milwaukee Oto-Ophthalmic Society

Members of the Milwaukee Oto-Ophthalmic Society met on February 23 at the University Club, Milwaukee, to hear Dr. Paul Boeder, chief physicist, American Optical Company, Southbridge, Massachusetts. He spoke on the topic, "Practical Considerations of Aniseikonia."

## Doctor Miller in Semi-Retirement

*Dr. Ernest Miller*, Milwaukee, has gone into semi-retirement at the age of 72, after 47 years in the practice of surgery. He served as chief of surgery

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at St. Mary's Hospital in Milwaukee for many years. Doctor Miller started practicing medicine in 1907 at Norway, Michigan, where he cared for the miners; later he moved to Hermansville, Michigan. He stayed in the Upper Peninsula for five years before moving to Milwaukee in 1912.

## Milwaukee and Madison Doctors Address the Wisconsin Bar Association

The midwinter meeting of the Wisconsin Bar Association held in Milwaukee on February 18 and 19 joined with the State Medical Society to hold a legal-medical institute. Doctors who spoke before the group and their topics were:

*Dr. Elston Belknap*, Milwaukee, "The Adequate Examination of an Injured Person."

*Dr. Elwood W. Mason*, Milwaukee, "Relationship of Symptoms and Complaints to Actual Injuries."

*Dr. Francis F. Rosenbaum*, Milwaukee, "Traumatic Heart Injuries."

*Dr. Christopher R. Dix*, Milwaukee, "Medico-Legal Aspects of Plastic Surgery."

*Dr. Francis J. Millen*, Milwaukee, "Evaluation of Neuropsychiatric Disabilities," and "Amnesia and Aspects of Neuropsychiatric Disabilities Resulting from Traumatology of the Nervous System."

*Dr. Herman W. Wirka*, Madison, "Intervertebral Disk and Back Injuries."

*Dr. L. J. Van Hecke*, Milwaukee, showed a film entitled "Films Showing a Complete Autopsy."

## Milwaukee

Several hundred members of the Medical Society of Milwaukee County gathered on January 14 at the Athletic Club to hear talks by Dr. M. E. Davis, Chicago, and *Dr. Amy Louise Hunter*, Madison. Doctor Davis is attending gynecologist at Chicago Lying-in Hospital and is associated with the Department of Obstetrics of the University of Chicago Medical School. He discussed delivery by cesarean section.

Doctor Hunter, who is director of the Bureau of Maternal and Child Health at the State Board of Health, Madison, gave statistics on maternal, fetal, and infant mortality in the state.

## Doctor Added to Milwaukee Staff of University of Wisconsin

*Dr. Thomas G. Malloy*, Milwaukee, has been added to the faculty of the University of Wisconsin in Milwaukee. He will be the medical specialist for the student health service.

Doctor Malloy is a 1945 graduate of the Marquette University School of Medicine.

## MARRIAGES

*Dr. Edward Vig*, Viroqua, to Miss Rosalyn Steinhorst, January 14.

*Dr. James L. Dean*, Madison, to Miss Ruth Ubbelohde, January 28.

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1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. *53*:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. *74*:261 (June) 1950.
4. Wolman, B., et al.: Brit. M. J. *1*:419 (Feb. 23) 1952.
5. Potterfield, T. G., et al.: J. Philadelphia Gen. Hosp. *2*:6 (Jan.) 1951.
6. King, E. Q., et al.: J. A. M. A. *143*:1 (May 6) 1950.

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## SOCIETY RECORDS

### New Members

Mary E. Van Vleet, 3042 North Prospect Avenue, Milwaukee.

J. R. Howlett, P. O. Box 176, Hartland.

V. P. Simmons, Department of Pharmacology, Marquette University, 561 North 15th Street, Milwaukee.

R. R. Jacks, Menard, Illinois.

D. A. Freed, P. O. Box 83, Elkhorn.

D. W. Springer, First National Bank Building, Monroe.

C. F. Althous, Hazel Green Hospital, Hazel Green.

L. J. Ganser, 310 North Orchard Street, Madison.

S. D. Austin, 130 East Walnut Street, Green Bay.

### Changes in Address

Ann Cinelis, Independence, to 926 High Avenue, Sheboygan.

R. A. Durham, Eau Claire, to Nassau Hospital, Miniola, New York.

D. W. Maas, Milwaukee, to VA Hospital, Wood.

C. L. Junkerman, Great Lakes, Illinois, to 2212 West State Street, Milwaukee.

O. S. Orth, Madison, to Route 1, Middleton.

T. W. Kirmse, Marinette, to 8700 West Wisconsin Avenue, Milwaukee.

T. J. Beno,* Green Bay, to U.S. Army Hospital, Camp Chaffee, Arkansas.

H. M. Bachhuber,* Fort Sam Houston, Texas, to 611 Park Street, Neosho, Missouri.

F. P. Krumenacher,* Milwaukee, to 1314 Washington Drive, Milwaukee.

J. F. McDonald, Milwaukee, to 104 Roney Island, Syracuse, New York.

L. J. Kreissl, Jr.,* Milwaukee, to 4507 North 41st Street, Milwaukee.

E. H. Schalmo,* Wauwatosa, to U.S. Army Hospital, Aberdeen Proving Ground, Maryland.

Kinge Hara,* Milwaukee, to A02260576, Hq. 50005th Hospital, A.P.O. 942–1, % Postmaster Group, Seattle, Washington.

J. L. Buhl, Hales Corners, to P. O. Box 225, Muskego.

R. J. Becker,* Milwaukee, to U.S. Army Hospital, Fort Benning, Georgia.

H. J. Kanin,* San Antonio, Texas, to 273 Menlo Boulevard, San Antonio, Texas.

J. C. Pinney, Washington, D.C., to 1301 South Webster Avenue, Green Bay.

J. H. Russell, Sheboygan, to 103 West College Avenue, Appleton.

A. J. Randall, Kenosha, to South Orange Avenue, Sarasota, Florida.

D. E. Matthiesen,* Green Cove Springs, Florida, to 513 Pelison, Corpus Christi, Texas.

J. S. Altman, Great Lakes, Illinois, to 2407 Buchanan Road, Kenosha.

A. H. Twyman Beloit, to VA Hospital, Madison.

R. P. Lyons, Madison, to Fort Atkinson.

I. M. Becker, Oakland, California, to 6430 North Santa Monica Boulevard, Milwaukee.

---

* Military Service.

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J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
James F. McDonald, Jr., M. D.
Wendell T. Wingett, M. D.

## DEATHS

Charles R. Kossat died in Milwaukee on January 27 at the age of 86. He was born in Germany in 1867 and came to Milwaukee as a young boy.

He was graduated from the Milwaukee Medical College in 1900. Doctor Kossat practiced in Milwaukee for more than 50 years, retiring about eight years ago.

Surviving Doctor Kossat are three daughters, Mrs. Hugo O. Hoffmann, Miss Vivian G. Kossat, and Mrs. Jacob Schlitt, all of Milwaukee.

Henry P. Haushalter, 84, a physician and surgeon in the Milwaukee area for over 50 years, died January 27.

Doctor Haushalter was born in Muscoda, Wisconsin, in 1869. He was graduated in 1901 from the Wisconsin College of Physicians and Surgeons, now a part of the Marquette University School of Medicine, and started his practice on the north side of Milwaukee. He was a member of the staff of St. Joseph's Hospital. Doctor Haushalter was a life member of the Medical Society of Milwaukee County and the State Medical Society and a member of the American Medical Association. He was also a member of the Fifty-Year Club of the State Society.

He is survived by his widow, Martha; two sons, Dr. Lester E. and Kenneth H., both of Milwaukee; two sisters; and a brother.

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Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry, and many others.

Address as follows: Medical Library Service. Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

**Clinical Diagnosis by Laboratory Methods.** By James Campbell Todd, Ph.B., M. D., late professor of clinical pathology, University of Colorado School of Medicine; Arthur Hawley Sanford, A.M., M.D., emeritus professor of clinical pathology, the Mayo Foundation, University of Minnesota; emeritus member, Division of Clinical Laboratories, the Mayo Clinic; director of laboratories, Rochester State Hospital; and Benjamin B. Wells, M. D., Ph.D, professor of medicine, University of Arkansas School of Medicine. Twelfth Edition. Philadelphia and London, W. B. Saunders Company, 1953.

This book has been a highly favored publication for many years and should continue to maintain the envied reputation of its predecessors. It is now in its twelfth edition and brings with it a series of minor changes in the third chapter on urine. Some new material has been added to the fourth chapter on blood and to the fifth chapter on blood chemistry. The twelfth chapter on bacteriologic methods has had some alterations to make it conform to the nomenclature and arrangement of the sixth edition of Bergey's *Manual of Determinative Bacteriology.* Extensive changes appear in the fifteenth chapter on serologic tests for syphilis. Technics discussed now conform to those published in Supplement No. 22, *Journal of Venereal Disease Information,* United States Public Health Service.

It should be of interest to all friends of Doctor Sanford to learn that he has chosen Dr. Benjamin B. Wells as a co-author for this edition. Doctor Wells is known to many as an excellent teacher and as the author of the book, *Clinical Pathology, Application and Interpretation.*—W.H.J.

**Pioneer Doctor.** By Lewis J. Moorman, M. D. Norman, Oklahoma, University of Oklahoma Press, 1951. Price $3.75.

Doctor Moorman was born in 1875 in Kentucky, practiced for a short time in Tennessee, and then in 1901 went into Oklahoma, where for six years he lead the life of a "horse and buggy" doctor on the plains. After postgraduate studies in Vienna, he moved to Oklahoma, became a tuberculosis specialist, and for a while dean of the medical school. The good doctor has seen much during a long life and tells his stories with gusto. He also gives extensive abstracts from the history of tuberculosis and his opinions on the latter disease and on the professional situation.—E.H.A.

**Films in Psychiatry, Psychology and Mental Health.** By Adolpf Nichtenhauser, M. D., Marie L. Coleman, and David S. Ruhe, M. D. Medical Audio-visual Institute of the Association of American Medical Colleges. New York, Health Education Council, 1953. Price $6.00.

This book consists of content descriptions and critical reviews of the available films in the area of emotional health. There is also a great deal of useful information concerning the running time of the films, where they may be obtained, and their purchase or rental cost—in short, most of the information required in making a selection of a film for a particular purpose. To my knowledge, this book is unique in bringing together this information and therefore fulfills a need which otherwise would require tedious previewing and searching. While one might with justification differ with some of the critical comment in specific instances, the information this book contains can be obtained nowhere else; it is, therefore, highly recommended to the persons seeking suitable films for educational use.—R.R.

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There are times when our thinking as to prepaid health insurance and the participation of the medical profession may easily be affected by problems of the moment. Sound consideration of the whole subject must constantly be returned to the fundamental reasons for the profession to be concerned with the problem at all.

The principle of voluntary enterprise in the health insurance field is one of the major planks in the entire "platform" of the profession. The American Medical Association and its constituent state medical societies have repeatedly emphasized the point.

But voluntary insurance can and is being offered by the insurance industry as such. Why, then, should the medical profession be itself engaged in an active program of its own?

It is because the profession has a certain something to offer that no one else can offer. That is the concept of "full payment," under which the benefits provided are accepted by participating physicians in full payment for services rendered a defined income level.

With commitment to an insurance program such as Blue Shield of Wisconsin, there are concomitant problems which must be determined under the principle that what is best for public health is by reason of that fact best for the medical profession.

Some of these problems fall in the field of policy determinations. Others are of an administrative character. Still others might best be characterized as means to an end.

Principal among them is that the stature of Blue Shield can not fall, directly or indirectly, under domination of forces whose ideals and whose training and obligations are not those of the profession itself.

Blue Shield can be advised by others, but it can be instructed only by formal action within the medical profession. These influences can emanate from many a diverse source. It may be the purchaser of the program who attempts to specify its content and is unappreciative of the complexity of insurance or that insurance itself can never insure what is a daily necessity of life. Nor should insurance become priced out of existence by the inclusion of minor benefits which, while perhaps of frequent occurrence, are individually small in dollar volume and expensive to administer.

These pressures may also develop out of the impact of administrative costs. Currently, the cost of the services performed by Blue Cross totals about two-thirds of the entire administrative cost of Blue Shield. Mechanisms to reduce these costs are being studied at the present time, in the hope that such a reduction will be reflected favorably upon those who subscribe to Blue Shield as well as to Blue Cross.

The Commission on Prepaid Plans constantly seeks to effect adequate liaison with the Blue Cross Board of Directors in the hope that both bodies will profit to the advantage of their respective programs and subscribers as each body becomes more keenly aware of the problems of the other.

Finally, the Commission must continue to be in the position it has asserted in the past —every tenet of the medical profession must be adhered to by Blue Shield. Blue Shield does not create those principles nor is it Blue Shield's responsibility to change them. Such responsibility is that of the medical profession through its various professional associations.

The medical profession holds that free choice of physician advances sound quality of medical care. Blue Shield complies with that principle.

The medical profession holds certain services in the specialty field to be medical services, benefits for which should be included in the Blue Shield contracts; and Blue Shield of Wisconsin complies.

The medical profession in Wisconsin holds that adequate standards of medical practice should be reviewed and controlled by the profession, and that if a question is raised concerning a specific physician, this is a matter for the medical profession to handle, at least in the first instance. Blue Shield complies.

In short, Blue Shield of Wisconsin is an integral part of the whole of medicine. It will be continued that way.

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# A New Form of Drug Therapy in the Treatment of Arthritis and Rheumatoid Conditions

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ARTHRITIS is a disease which has plagued man since his existence, as proved by human skeletons found in the oldest excavations. It is a disease whose cause, treatment, and cure have evaded us through centuries. Even with the great advances made in medicine in recent years and the great effort which has been spent in research, we still remain in the dark.

The disease is not a great killer; but it causes unlimited suffering and pain, with considerable loss of work hours, because of its crippling effects. In localities where the weather is damp, as in the areas along the Great Lakes, the incidence of the disease is unusually high; and it seems that almost everyone over forty has some form of arthritis to some degree.

Many drugs such as gold, colloidal sulphur, salicylates, ACTH, and cortisone have been tried; but most of them have been discarded because of toxic symptoms or poor results. The only ones which have stood the test of time are the salicylates. In recent years it has been felt that the reasons for their beneficial results are being unfolded and that the pharmacological and physiological actions can be explained to a certain extent. Up to the present time, we knew they worked and were fairly safe but didn't know how they worked.

Using salicylates has drawbacks, too—(1) overdosage causes symptoms of salicylism; (2) some cause gastric irritation in a high percentage of individuals; (3) increased bleeding due to lowering of the prothrombin time; (4) blood dyscrasias in certain individuals; and (5) allergic manifestations in many. Furthermore, salicylates alone do not relieve severe pain. Even years ago, salicylates were prescribed with sodium bicarbonate to eliminate gastric irritation. They have been combined with PABA (Para-aminobenzoic acid) to build up higher salicylate blood levels with much smaller doses of the drug. They have been enteric-coated to relieve gastric irritation, but in many instances the tablets do not disintegrate and may cause mechanical irritation as they pass through the gastrointestinal tract.

Because of the pain, most arthritic patients have a great deal of associated skeletal muscle spasm, which is nature's method of eliminating movement. If the process goes on for any length of time, atrophy of muscles occurs, with resulting deformities and stiffness of the joints.

Recently a new skeletal muscle antispasmodic, mephenesin, sold under such trade names as Tolserol and Oranixon, came on the market. It has many uses and is given both orally and intravenously. The drug is used for sedation in nervous and mental patients, for sedation and relief of tremors in alcoholism and delirium tremens, and for the relief of skeletal muscle spasticities. The intravenous route has its dangers; and since the drug is well tolerated by mouth, the intravenous use is limited. The drug is very low in toxicity, and it must be used in large oral doses to be effective. Many of the unsatisfactory results following oral therapy are due to inadequate dosage. Our results indicate that the drug is of questionable value in mental and nervous patients, and its influence on the central nervous system as a depressant or sedative is minimal. It does work excellently in alcoholism, and usually the individual quiets down within 24 to 36 hours on adequate oral dosage at 2 or 3 hour

intervals. The tendency towards jitteriness and nervousness leaves; the patients sleep and begin to eat.

Mephenesin is effective in skeletal muscle spasticities; it relaxes skeletal muscle spasm in such conditions as myositis; stiff neck; and spastic back conditions, both acute and chronic.[1,2]

Nesbitt[3] used oral mephenesin with diathermy in 106 cases of spastic skeletal muscle conditions and compared the results with those in 59 control cases which received aspirin (or placebo) and diathermy; 88.7 per cent returned to work on or before the third day, with minimal or no symptoms. In the control group, only 49.2 per cent were able to return to work on or before the third day of treatment. He noted no toxic effects in any of the 106 cases.

Our results with mephenesin have also been favorable in acute spastic muscle conditions; however, the drug does not directly relieve pain. We found that, in arthritic conditions, it is necessary to combine the drug with an analgesic such as aspirin, a salicylate, or codeine to obtain relief from pain.

In arthritis the ideal drug would be one which would cure the disease. Since such a drug does not exist at the present time, it was decided to find a combination of drugs which would at least relieve both pain and spasm. If an arthritic patient is free from pain and stiffness, he at least is comfortable, can get around, and can carry on his duties.

Various combinations of drugs were tried, and the most satisfactory combination was Salimeph–C* (trademark), a tablet which contains salicylamide, 250 mg.; mephenesin, 250 mg.; and ascorbic acid, 15 mg. In this preparation, salicylamide provides pain relief, mephenesin relaxes skeletal muscle spasm, and ascorbic acid (Vitamin C) compensates for depletion of ascorbic acid caused by the salicylate.

Salicylamide is a salicylate which can be taken in relatively large doses over a long period of time without any gastric irritation.[4,5] Two hundred fifty milligrams of salicylamide is approximately equivalent in analgesic effect to 5 grains of aspirin. To be effective in arthritis, any drug must relieve pain and spasm; be nontoxic; induce no side effects, immediate or delayed; have no bad effects on the blood; be safe to administer over a long period of time to a person of any age; have no contraindications; give no gastric irritation; and be reasonable in price. In our experience, Salimeph–C meets all of these requirements. It has been used clinically in a series of 200 patients with excellent results. These cases were unselected as to age or other existing medical conditions. Patients with arthritis in any form, acute or chronic; myositis; or any painful muscle conditions, regardless of the cause, were placed on the medication. Many were bedridden and crippled; several had been given other forms of therapy, including ACTH and cortisone, and had failed to respond.

The drug was given in doses of 2 or 3 tablets, 3 or 4 times daily after meals, preferably with one third glass of milk. This dosage was found to be the average for most individuals. However, the safety of the drug allows it to be given in dosages as high as 3 to 5 tablets, 3 to 5 times daily. Occasionally patients may complain of slight giddiness on such a dosage schedule. If this occurs, the dosage should be reduced but not discontinued. Patients usually respond to the average dose in 2 or 3 days with cessation of the pain and stiffness. After the symptoms have cleared, the ordinary patient can be kept symptom free with 1 or 2 tablets daily. Even weather changes do not produce the usually recurring symptoms.

The drug should be given after meals, preferably with milk, to eliminate a transitory dizziness which may occur if given on an empty stomach. We observed this effect in only 2 cases. When the patients took the medication after meals, their distress was relieved.

No patient complained of any other side effects such as gastric irritation, excessive perspiration, or salicylism. Some individuals who are allergic to salicylates may not be able to take the drug. However, one 65-year-old male with an arthritis of the back, who had a coronary occlusion two years ago, could not take aspirin because it caused difficulty in breathing but was able to take Salimeph–C with good results. It relieved his arthritic pains, and he tolerated the drug well without any allergic symptoms. Perhaps individuals who are allergic to salicylates may be able to take them in the form of salicylamide or in combination with mephenesin.

It is the author's impression that a great many individuals cannot tolerate aspirin or salicylates, not because of the allergic fac-

*Salimeph–C is supplied by Kremers–Urban Company, Milwaukee, Wisconsin.

tor, but because of gastric irritation. This manifests itself by pain, cramps, heartburn, gas, and irregularity of the heart.

Salimeph–C was used in all age groups, including children, old people, individuals with heart disease, diabetics, and arteriosclerotics; unlike results in using other drugs, no harmful effects and no reasons for discontinuing the medication were found. Thus far, in close observation of patients, no form of blood disturbance has been found.

Salimeph–C will not completely alleviate severe pains which require codeine or morphine. In injury cases where the pain was very severe, codeine was given for the first few days. Thereafter it was discontinued, and the patients were comfortably maintained with Salimeph–C. There are no contraindications to other drugs with this medication. Physiotherapy, vitamins, and other preparations used in treatment may be used adjunctively.

In many of these patients having a combination of arthritis, neuritis, and neuralgia, injections of crystalline vitamin $B_{12}$, 1000 mcg. per cc., were also used. Injections of 1 cc. of the $B_{12}$ were given subcutaneously with a hypodermic needle every other day. The injection is painless and gives no local or systemic reaction. Because of the prolonged use of drugs and inadequate diet, many arthritic patients are anemic. The $B_{12}$ serves a dual purpose; it relieves the neuritic pain, regardless of the etiology, and builds up the blood count very rapidly. The patient eats well, feels stronger, and has more energy; and the muscle and arthritic pains become less severe.

The results thus far have been extremely good. Almost every patient in this series has volunteered the information that the pains have disappeared completely or have been relieved to the extent that he is no longer conscious of them. Stiffness has disappeared so he can work and carry on without any discomfort. Many who were crippled and bedridden are now out of bed and can get around without assistance.

Several older individuals have been concerned about their stiffness. The pain was so great that they feared they would have to quit their jobs and cease to be self-sustaining. All of the patients in this series improved enough to carry on their work and have been relieved of their mental anguish.

In strains, traumatic conditions, and industrial injuries involving the back, shoulders, arms, and neck, the drug has worked out very well. However, in these cases codeine, physiotherapy, and other forms of therapy were also used. It was found that the period of disability was cut down and that the patients returned to work sooner when Salimeph–C was used. As would be expected, the drug does not relieve the pain in calcified bursitis or slipped disks.

## Summary

In a series of 200 cases* of arthritic and myositic conditions, acute and chronic, associated with pain and skeletal muscle spasms, Salimeph–C gave excellent results.

It is the author's impression that Salimeph–C is an excellent drug in the treatment of these conditions. It is a combination of salicylamide for analgesia, mephenesin for relaxation of skeletal muscle spasm, and ascorbic acid for nutritional supplementation.

The drug is safe and is reasonable in cost. It can be used in any age group, alone or adjunctively. There are no contraindications other than allergies due to its component drugs. Side effects were minimal (giddiness in two patients), and administration did not have to be discontinued in any case because of intolerance. The drug can be administered orally over prolonged periods and is not habit-forming.

Although Salimeph–C does not cure arthritis and rheumatoid conditions, it does relieve pain and spasm. Therefore, it should be extremely valuable in the treatment of the many who suffer from these conditions.

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* Since presentation of this article, the author has used this drug in 500 cases.

208 East Wisconsin Avenue.

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# The Harvey Hospital*

By WILLIAM S. MIDDLETON, M. D.**
Madison

## PART I

PRESIDENT Abraham Lincoln suggested "Harvey United States Government Hospital" as an appropriate designation for a military hospital to be located in Madison during the fevered days of the Civil War. This circumstance alone would arrest the historian's attention; but many other incidents attendant upon the establishment of the hospital require careful study for their elucidation. The military policy of the United States Army at that period emphatically opposed the development of hospitals and convalescent centers removed from the areas of active campaigning. Particularly were obstacles placed in the way of the movement of convalescent soldiers who might anticipate a return to active duty, after the early period of the war. What extenuating circumstances reopened this question? What forces were brought to bear to lead to the abrogation of a sound military precedent? Whose influence carried the day? Why was Madison selected as the site for a military hospital? What led to the choice of the name? The answers to these questions are available, and the history of this detail of the military medicine of the Civil War forms an absorbing chapter of Wisconsin lore.

The conventional historical accounts bear the telltale repetitiveness of the limited sources. Casual surveys leave much to be desired in fact-finding studies of the contemporary materials. In this instance the quest is enlivened by the sharp political division of the period. The *Wisconsin State Journal* was the Republican medium and staunchly supported Lincoln and his policies. As the official paper of the state, it enjoyed the financial support and prestige of the publication of state documents. The *Argus* gave reluctant lip service to the Government and reserved the privilege of free criticism at the slightest provocation. The weekly and daily *Wisconsin Patriot* were Democratic in their political complexion. By the most liberal construction, their tone and attitude cannot, even at this removed period, be deemed patriotic. While these newspapers prated loudly of their loyalty and vigorously resented the opprobrious label, "Copperhead," the acerbity and vituperation of their attacks on the administration leave little doubt of their sympathies. The feud between the Madison papers was a byword of the day. Because of financial difficulties, the *Patriot* suspended publication November 14, 1864, whereupon a strange calm and peace settled upon the journalistic atmosphere of Wisconsin, even though the strident, discordant note was doubtless missed for a season.

The location of Camp Randall in Madison was not an unmitigated blessing. True, the presence of so many young men in the capital of the young state accelerated the tempo of its social life. Many private and public affairs were arranged for their entertainment. Reciprocally, the bands of the several regiments in training participated in civic celebrations quite regularly. On occasion the Madison newspapers took unqualified positions supporting the soldiers. Early in 1862 several episodes involving the discipline at Camp Randall shook the confidence of the citizens of the community. On February 7 the *State Journal* reported the death of James Pollock from typhoid pneumonia and of Hortopp, of Company H, the cause of whose death was cardiac disease, as determined by a necropsy performed by Drs. McKennan and Carey, Army surgeons. Professor Ezra Carr, of the Department of Chemistry of the University of Wisconsin, studied the gastric contents of this soldier and reported the absence of any poison. "In spite of this we hear that a charge of poisoning was made the other day to one of the surgeons by a non-commissioned officer who objected to the administration of a Dover's

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*Read before the William Snow Miller Medical History Seminar, University of Wisconsin Medical School.

Acknowledgement of valuable source material is gratefully made to Mr. Emil J. Frautschi and Mr. Walter A. Frautschi. The photographs herein reproduced were afforded through the courtesy of the State Historical Society of Wisconsin.

**Dean, University of Wisconsin Medical School.

powder because it was the same as that given to the deceased."

The *Weekly Argus* (February 18, 1862) reported the passage of a bill by the Senate prohibiting the sale of liquor to soldiers within 3 miles of any camp in the state, under penalty of a fine of $25. The *Argus* warmly supported the measure and cited its growing concern for the safety of civilian men and women at the hands of drunken soldiers. It continues, "and then if a certain privileged set of men that constitute a fraction of our regiment continue in their *aristocratic* courses, we shall know where the blame lies." The people of Madison were truly alarmed when open mutiny of the 17th Regiment, under orders to leave for the South, broke out on the night of March 19-20, 1862. In the disturbance a 200-foot barracks at Camp Randall was burned to the ground, and even greater destruction was threatened. Two soldiers lost their lives. The soldiers accused their command and the civil authorities of a breach of faith in their failure to afford the promised relief to their families and personal pay to themselves. Indeed, in a message to the Legislature (February 25, 1862), Governor Harvey had appealed for the expedition of the extra pay to the dependent families of volunteers. Three thousand claims in the hands of the Secretary of State were at that time unfilled. The Governor wrote: "I have preëmptory and repeated orders to forward at once the 14th, 15th, and 16th regiments to St. Louis. The officers and men, I doubt not, will promptly obey orders to leave, but they will not go with the heart Wisconsin volunteers should bear to the field. Money cannot compensate the loss of courage, and hope and pride in this State, under which they will reluctantly lengthen the distance between themselves and their suffering households."

The officers were unable to bring the mutineers under control. The predominance of soldiers of Irish origin in the 17th Regiment had given it the prized designation, the Irish Regiment. Poetic license brought 160 Mulligan guards from another unit to restore order. More effective was the personal appearance of their champion, Governor Harvey, who promised a prompt adjustment of their fair complaint. Yet the *State Journal* (March 20, 1862) recorded: "At a little before four o'clock this afternoon the first

Fig. 1—Camp Randall, May 1864 (from lithograph by Louis Kurz). The post hospital is at the extreme right.

train of cars, with about half the regiment on board, left the depot. The other train was still at the camp grounds, and it was doubtful whether it would go. Great confusion prevails at camp. Utter insubordination exists. Many of the men are reported to be intoxicated, and all is confusion and uproar. If this continues, a strong armed police should be organized to patrol the city tonight, and prevent disorder and violence." On March 28 Governor Harvey left for St. Louis to insure the fulfillment of his promise.

Louis Powell Harvey was born in East Haddam, Connecticut, on July 22, 1820. The Harveys migrated to Ohio in 1828. Young Harvey attended Western Reserve College, Hudson, Ohio, for 2 years; in 1837, ill health interrupted his educational program. His classmate, Rev. William Brown of La Crosse, recalled, "He was a noble youth. With brilliant talents, good scholarship, and pleasing manners, he became a favorite among his fellow students. Impulsive in temperament, of unbounded wit and humor, yet chastened by Christian principles." Upon his withdrawal from college he taught for 2 years at the academy in Nicholasville, Kentucky. A similar period found Harvey serving a tutorship at Woodward College, Cincinnati. In 1841 he moved to Southport (Kenosha), Wisconsin, where he remained for 6 years. Here he resumed teaching in a structure which had been built as an academy. Later he was appointed postmaster by President Polk. Then he assumed the editorship of the Whig newspaper, *Southport American* (1843). Political differences lost him patronage and the postmastership; but integrity and independence always characterized his personal as well as his political life. In 1847 Harvey married Cordelia Perrine and moved

to Clinton, Rock County, to engage in general merchandising. Only one daughter was born to this union; she died in early childhood. In 1851 they moved to Waterloo (now Shopiere), Rock County. Harvey purchased the water power plant and the distillery. He razed the latter and built a flour mill in its place. He established a retail general merchandise store. A total abstainer, he was very active in the affairs of the Congregational Church.

During his Cincinnati sojourn Harvey showed his first political interest by speaking at a Whig meeting in Brunswick, Ohio. An easy, fluent speaker, he swayed his audiences by his native courtesy and humor rather than by the invective so rampant in that period of American politics. So great was his personal popularity that he regularly outstripped the rest of the ticket in local elections. Wider public notice of his abilities attended his superior performance as a member of the convention to frame the Constitution of Wisconsin (December 16, 1847). His election as state Senator (1853) was a natural sequence. He served in this chamber for 4 years and for his last term was president *pro tem.* In 1859 Harvey became Secretary of State and *ex officio* School Land Commissioner. As Governor, he was officially president *pro tem* of the Board of Regents of the University of Wisconsin; but in the meager minutes of that period, no notice of his attendance or participation in its meetings is encountered. The meteoric rise of Harvey was crowned by his election to the governorship when 41 years old by the largest majority (5,462) yet accorded a state candidate in the young commonwealth. In politics he had changed from a Clay Whig to a member of the new Republican Party. As an open opponent of slavery, he had fought the Wilmot Proviso. Incapable of intrigue, he had the confidence of the electorate.

However, the editor of the *Argus* was reluctant to concede the Republican victory. On November 8, 1861, three days after the election, he wrote: "The vote upon State officers is likely to come out closer than at any election since the year that Bashford was elected, though we think the Republican Union ticket is elected throughout. There is a 'smart chance' that the Assembly is democratic.

"This should serve as an admonition that the Republican Party is not so strong that it can carry everything. We venture the prediction that if it attempts to shoulder Governor Randall's war administration and the great Land Grant corruptionists, in another two years it will be blown higher than a kite. Will the Republicans take warning in time, or must foolhardness (*sic*) prove their ruin?"

Fig. 2—Governor Louis P. Harvey.

On January 6, 1862, Louis Powell Harvey was inaugurated as Governor of Wisconsin in the presence of a large concourse of representative citizens, state officials, and soldiers. The oath of office was administered by Chief Justice Dixon. On the following evening a reception was tendered in the newly refurbished Assembly Hall. The 12th Regiment Band afforded the music. Addressing the joint session of the Assembly and Senate (January 10, 1862), Governor Harvey said: "No previous legislature has convened under equal incentives to a disinterested zeal in the public service . . . The occasion pleads with you in rebuke of all the meaner passions, admonishing to the exercise of a conscientious patriotism, becoming the representatives of a Christian people, called in

God's providence to pass through the furnace of a great trial of their virtue, and of the strength of the Government." The Governor's message was an orderly discussion of the pressing problems of the period. Its forthrightness and nonpartisanship commended it to most contemporary commentators. While dissenting in some important details, the *Argus* was constrained to say (January 14, 1862): "After a careful perusal of this document it affords us great pleasure to be able to say that in our judgment it is the most manly and statesmanlike document which has proceeded from the Executive Chair of this State in many years and from our accustomed freedom in speaking of such matters, our readers will understand that we mean just what we say. It is a plain, dignified, intelligible businesslike document throughout and no spread eagles, bombast about it." Editorially, the *State Journal* (January 11, 1862) took umbrage at Governor Harvey's designation of the purchase of state lands as "a cheat and a delusion." Although such lands were temporily unproductive, the state stood in the position of ultimate gain through purchase monies, interest, and taxes.

Governor Harvey maintained his interest in the welfare of Wisconsin soldiers. On April 8, 1862, he addressed a letter to Hon. S. D. Hastings, urging the immediate passage of the allotment bill by the Assembly. Over 5,000 Wisconsin troops in camp looked to this action for financial assistance under which the accumulating claims would be honored. While this issue was being actively pressed in Madison, disquieting information of the plight of sick and wounded Wisconsin men after the terrible battle at Pittsburg Landing (Shiloh) (April 7, 1862) began to filter through regular and irregular channels. With the assistance of an aroused citizenry, Governor Harvey organized a representative inspection party to visit the battleground and hospitals to gain first-hand information and to lend such assistance as might be possible under existing conditions. The party, including 9 surgeons, left Madison on April 10, 1862. On 74 hours' notice, 90 boxes of hospital supplies and medical comforts had been collected for distribution. These materials were carried without charge by the Illinois Central Railroad. The succeeding days were crowded with activity. Fortunately, letters from Governor Harvey have been preserved and afford a clear picture of his observations and reactions in that tragic milieu. On April 19, 1862, the *State Journal* published this communication from him: "I have today (Sunday) been through the hospital at Mound City, six miles above Cairo, where are not less than 1,000 sick and wounded soldiers. It is the grandest affair of a hospital one can conceive of. A block of some ten fine brick stores, three stories, built in speculative times and abandoned, has been appropriated — each store making three wards, one above the other. The whole is clean, admirably arranged, well ventilated; and the provision of comfort and care, including medical attendance, seems abundant and excellent. Dr. Whiting, of Janesville, is at Mound City assisting Doc. Franklin, the Physician who has charge of the hospital.

"I have found some thirty Wisconsin boys here. They appeared cheerful amid their sufferings, grateful for care and kindness shown them, and much cheered by our friendly call and the encouraging words we could give them."

Governor Harvey also visited hospitals at Paducah and Savannah. From Pittsburg Landing under date of April 17, 1862, came two messages in the same vein. To Secretary Watson he wrote:

"Dear Watson: I have taken J. M. Bundy with me, who corresponds for the *Wisconsin*. He gives his whole attention to the work and you must look to the *Wisconsin* for details. I have not time to write.

Thank God for the impulse which brought me here. I am doing a good work, and shall stay as long as I am profitably employed.

In haste,

L.P.H."

To Mrs. Harvey, his note read:

"Dear Wife: Yesterday was *the day* of my life. Thank God for the impulse that brought me here.

I am well, and have done more good by coming than I can well tell you.

In haste,

LOUIS"

Upon the heels of these reassuring letters came overwhelming tragedy. Apparently Governor Harvey believed that his mission had been discharged. The night of April 19 was rainy and dark. Transportation to Savannah was taken on the steamer "Dunleith." Here a transfer to the steamer "Min-

nehaha" for Cairo, where the Illinois Central Railroad would carry the party north, had been arranged. When the Governor moved toward the stern of the "Dunleith" as the two boats were brought together, he apparently misgauged the distance between them and plunged into the Tennessee, which is very deep and swift at this point. A member of the party, Dr. Wilson of Sharon, quickly extended a cane which was snatched from his hands by the struggling Governor. Dr. Clark, of Racine, leaped into the river in a futile attempt to save him. The swift current carried his body 65 miles downstream, where it was recovered below Savannah.

Captain William Walker, of the steamer "Lady Pike," learned that the body of Governor Harvey had been found by some children (April 27, 1862). They reported that a Negro had rifled the pockets. The body had been buried but Captain Walker had it disinterred. The neighboring residents located and completely restored the personal belongings. Perry H. Smith, vice-president of the Chicago and Northwestern Railroad, who took charge of the remains, wired from Cairo on May 4, 1862: "We leave Cairo with Governor Harvey's body tonight; will reach Chicago at nine o'clock P. M. We have his watch, pencil, and all his papers."

The shock of this tragedy overwhelmed both the citizens of Wisconsin and the soldiers in the field who had come to trust Governor Harvey as a true friend. Their reaction has been preserved by J. M. Bundy, who wrote:

"He had brought comfort, courage, and substantial relief to men who, after that Pittsburg battle, needed these if ever men did. He accomplished much more, in every way, than any other man, that I know, could have accomplished under the same circumstances. For his suavity of manner, and energy of purpose, had won from the authorities privileges which were at first flatly refused, and his goodness of heart had won the hearts of the soldiers while at all points of our journey he had made friends and admirers among those who had never before heard of him."

The grief of his friends and associates was profound. His successor, Edward Salomon, published this proclamation on April 29, 1862:

"Whereas it has pleased Almighty God to take from the people of this State its Chief Magistrate, Hon. Louis P. Harvey, who on the 19th day of this month lost his life in the waters of the Tennessee River while executing a noble and self-chosen mission of philanthropy, in trying to recover from the recent battlefield in Tennessee, the dead, and to alleviate the sufferings of the wounded soldiers of this State; therefore,

"I, Edward Salomon, Governor of the State of Wisconsin, on assuming the duties of this office devolved upon me by that sad event, do hereby, in behalf of this State, tender to the bereaved widow of its late beloved Chief Magistrate, the deep and sorrowful sympathy and condolence of its people.

"And I do further appoint Thursday, the first day of May, A. D., 1862, as a day of rest and cessation from business, and recommend to the people of this State that on this day, between the hours of 10 and 12 o'clock in the morning, they assemble in their respective towns, cities, and villages, then and there to commemorate the death of the late Governor, the Hon. Louis P. Harvey, by such demonstrations as may be appropriate to the occasion.

"In testimony whereof, I have hereunto signed my name, and caused the great Seal of the State of Wisconsin to be affixed.

Done at Madison, this twenty-second day of April, A. D., 1862.

JAMES T. LEWIS, *Secretary of State*,
EDWARD SALOMON, *Governor*"

The rival newspapers carried extended accounts of the memorial services. Many organizations drew up resolutions commending the high personal attributes and civic contributions of Governor Harvey. His body lay in state in the Assembly Chamber under military guard; but circumstances limited this formality. Under the supervision of undertaker Fitch, the hearse was covered with black and white crepe surmounted by black and white plumes. The hearse was drawn by four white horses bearing black plumes. Each horse was led by a groom clothed in black. A guard of honor of 18 soldiers with reversed arms, selected from the 19th Regiment, marched on either side of the pallbearers. Engines from the two fire companies and the truck of the Hook and Ladder Company completed the procession. These latter elements left the line of march at the park. The funeral party continued to Forest Hill Cemetery, where the services were read by the Rev. Mr. Kinney, of Janesville.

The good works that Governor Harvey had initiated were not consummated during his lifetime. In a joint message to the Senate and Assembly, on June 3, 1862, Governor Salomon said: "It has been a source of very great embarrassment to the Executive De-

partment that no provisions had been made for the contingencies which have arisen since your adjournment, concerning the sick and wounded soldiers from our State. Wisconsin has sent into the field 24,000 men, and a new regiment is now being organized. As our army has advanced, a great many of our brave soldiers have become sick, and many have been wounded upon the battlefield. Especially has this been the case in the Army of the Mississippi. After the battle of Pittsburg Landing my lamented predecessor went to the battlefield to aid and assist the wounded. What he had so nobly commenced, I did not hesitate to carry out, so far as having those soldiers transported to their homes who had by him been sent up the Mississippi River. Subsequently, when reliable and continued accounts reached me of the helpless condition of our sick soldiers along the Tennessee River, of the inadequate relief granted by the United States authorities; when a battle was hourly expected, and when I was actually and credibly informed that a great battle near Corinth had commenced, I sent another commission under the charge of the Commissary, General E. R. Wodsworth, and the Surgeon General, Dr. E. B. Wolcott, to Pittsburg Landing; and although no battle occurred then, the commission, consisting of gentlemen who volunteered their services, saved the lives of many brave Wisconsin soldiers who were lying sick from the effects of the climate, and who would have died, had they not been removed. Since then, all State aid has been excluded by the military authorities until after a battle. But in that event aid ought again to be granted to those who fall wounded upon the field.

"I trust that you will sanction what has been done, and will speedily make provision for future emergencies. The great and noble State of Wisconsin ought not to let her brave sons, who fight the battles of the Union, die for want of attention. The people, the poor, sick, and wounded soldiers, look to the Executive for aid in such emergencies; but his hands are tied unless you will place the necessary means at his disposal. The expenses of such expeditions are necessarily large, notwithstanding the gratuitous services of physicians and nurses.

"I transmit to you herewith for your information, copies of the reports, in detail, of two expeditions sent to Keokuk and to Pittsburg Landing, and also the report by the Surgeon General of the operations of the last mentioned expedition.

"Aside from such expeditions, in cases of emergency, there are constantly claims made upon me in individual cases. It is but very recently that the general government has made provision for the transportation of such sick and wounded soldiers as have money due them from the Government. Those who have no pay due them will not be furnished with transportation, but must shift for themselves. In the cities of New York, Cincinnati, St. Louis, and other places, there are constantly arriving some of our sick and wounded soldiers, anxiously expecting to find some agency from our State that will aid them to get to their homes. Something should be done to relieve these poor, suffering men; many a life may be saved, and many a heart made glad. I am confident that the proud state of Wisconsin will not remain behind her sister states in that respect. Accompanying this I lay before you copies of a few of the many communications I have received concerning the necessity of appointing State agencies to look after the sick and wounded soldiers from Wisconsin."

On June 5, 1862, the Legislature voted Mrs. Harvey the salary of the governor for the full term. In addition, a sum of $200 was appropriated for a stone for the grave of the late Governor and an added $500 for those whose efforts had recovered his body. A further appropriation of $300 was made for the construction of an iron railing about his grave (June 17, 1862). At her personal request, Mrs. Harvey was made a Sanitary Agent by Governor Salomon. She forthwith proceeded to St. Louis and with characteristic vigor visited Wisconsin sick and wounded soldiers in all of the military hospitals of the surrounding area. She won the soldiers' tribute, "Wisconsin angel"; but by reason of her unaccustomed effort and exposure, she experienced a serious illness. The *Wisconsin State Journal* for March 30, 1863, published the following revealing picture of Mrs. Harvey's experiences and reactions:

"Governor Edward Salomon
Madison, Wisconsin

Dear Sir: It is and has been next to impossible to send you anything like a correct report of what I am and have been doing. For the last few weeks I have been laboring constantly in hospitals, seeking out soldiers broken in health to such a degree that they could in no possible way be of any further service to their country, and bringing such cases before

the medical authorities, who, upon examination, discharge them. In this way I trust many a human life has been prolonged, at least until they reach their homes. This I believe to be just and merciful—just to the Government, and merciful to the man.

"The weather is quite warm, like our June days, and to our poor suffering ones in hospitals it is very debilitating. Hope, courage, and finally life itself fails them. Death is at present discharging more rapidly than the authorities. Oh, how we feel the necessity of Northern hospitals now; could the 'Water Cure,' at Madison, have been fitted up by the Government for a military hospital, many a valuable life might have been spared to Wisconsin, and to the service, that must now go out in Memphis.

"How our dying ones look with longing eyes and outstretched arms northward, and with their last breath ask, 'Can't we go home?' I have seen unwritten histories, witnessed untold sufferings borne with heroic endurance in these hospitals, that I shall never forget. I know that love of country and true patriotism is no myth, but a reality, upon whose altar many a human life is freely offered a willing sacrifice.

"I send you a list of men brought up from Vicksburg, and placed in a new hospital opened the 10th of this month. It is just as nice and comfortable as it can be. Many wept for joy when they found how kindly they had been cared for. I have visited the 8th regiment, now gone to Vicksburg, and the 12th, 33rd, and 32nd regiments, and the 2nd cavalry, now in camp here. I have carried them sanitary goods and vegetables, as they have needed.

Yours respectfully,

Mrs. C. P. Harvey
*Ag't. for Wisconsin*"

Her case becomes much clearer when the scene is shifted from modern sanitation and hygiene to a period before bacteriology had emerged as a science and when intestinal infection was so rampant as to determine the outcome of military campaigns. Mrs. Harvey laid her plans well.

Meanwhile, in a message to the Senate and Assembly, Governor Salomon disclosed the further developments (*Weekly Wisconsin Patriot*, January 24, 1863):

"Of this fund there has been expended up to the present time, the sum of $10,828.94, leaving $9,171.06 yet undrawn. A detailed report of these expenditures and of their nature, and the purposes for which the money was used, and the general results obtained, will soon be laid before you. During the sickly season of last summer several expeditions, consisting of physicians and nurses, were sent South to bring sick and wounded soldiers from our State to their homes, or to northern hospitals; and such expeditions were subsequently, on several occasions, dispatched to battlefields after severe battles in which troops from our State had taken part. These expeditions have all been under the charge of the Surgeon General, and have been of greatest usefulness to the wounded soldiers, adding much to their comfort and immediate help; and great credit is due to the Surgeon General and the philanthropic gentlemen who, always without compensation, accompanied him, for the manner in which they always discharged their missions. Often have I heard of the touching scenes that took place on the arrival of these parties, when the gallant unfortunate men could not repress their tears on seeing that the State followed them upon the battle field, tendering them the aid and comfort which they so well deserved and were in need of.

"At the beginning of the war and up to last summer sick and wounded men were generally permitted to go home to recruit their health, and were granted limited furloughs for that purpose. This system led to much abuse, and to the diminution of the army to such an extent that the government adopted the rule, to which it has since rigidly adhered, of refusing all furloughs, keeping the sick and wounded soldiers in government hospitals, and authorizing their discharge if unfit for further service. Last fall, with governors of many other states, I presented a request to the President to change this system to some extent, by establishing hospitals in the several states and removing as much as possible the sick to the respective hospitals in their own states, where they would be nearer their friends, and where, to a limited extent at least, the system of furloughing such as could go to comfortable homes could safely be carried out. Prior to this I had repeatedly and urgently applied for the establishment of a hospital in some proper place in our State with a view of having our sick and wounded removed thereto. The reason why these requests have not been granted is the one, I presume, which induced the Government originally to cease the system of furloughing. I am not prepared to deny that the present system is on the whole the best, and one dictated by necessity; and I will here take occasion, from my own observations and from all the report I have received from reliable sources, to bear witness to the really excellent manner in which the government hospitals are generally kept. It is true, complaints have often been made, and in many instances undoubtedly justly made, of improper treatment of men in hospitals, but in many cases where such complaints reached me, and where I always caused investigation to be made, I have been subsequently convinced that the complaints were without foundation, and emanated from some worthless source."

Having stated the situation clearly, Governor Salomon proceeded,

"I recommend that you memorialize the President upon this subject [discharge of the disabled], as also upon the subject of establishing a hospital in this State, to which a large portion of our sick and wounded might be brought."

Meanwhile, Mrs. Harvey's resolution bore fruit through the good offices of Senator Doolittle of Wisconsin, who obtained an audience with President Lincoln for her. In *The Life of Abraham Lincoln*, Josiah Gilbert Holland recounts the historical interchange between these notable figures. The President was coolly courteous but openly hostile to the reopening of the question of regional or local

Fig. 3—Mrs. Cordelia P. Harvey.

hospitals for the reception of Union soldiers in their home states. Mrs. Harvey pressed her issue by stating, "that many soldiers, sick in our western army on the Mississippi, must have northern air, or die. There are thousands of graves along the Mississippi and Yazoo, for which the Government is responsible—ignorantly, undoubtedly; but this ignorance must not continue. If you will permit these men to come North, you will have ten men in one year where you have got one now."

Mr. Lincoln countered with a statement of the experience with desertion from the Army:

" 'How many men of the army of the Potomac do you suppose the government was paying at the battle of Antietam? And how many do you suppose could be got for active service at that time?' She replied: 'I know nothing of the army of the Potomac except that it has made some noble sacrifices.' 'Well, but give a guess,' persisted the President. 'Indeed, I cannot,' was her answer. He threw himself awkwardly around in his chair, with one leg over the arm, and spoke slowly: 'This war might have been finished at that time if every man had been in his place who was able to be there; but they were scattered here and there over the North—some on furloughs, and in one way or another gone, so that, out of one hundred and seventy thousand men, whom the Government was paying, only eighty-three thousand could be got for action. The consequences, you know, proved nearly disastrous.' The President paused for a response, and it came. 'It was very sad; but the delinquents were certainly not in northern hospitals, nor were they deserters from northern hospitals, for we have had none: so your argument is not against them.' "

Her mettle won a note to Secretary Stanton which read: "Admit Mrs. Harvey at once. Listen to what she says. She is a lady of intelligence, and talks sense. A. Lincoln." This conference was fruitless, since Stanton had just detailed the Surgeon General to New Orleans for a survey of all of the army hospitals north of that port along the Mississippi River. Mrs. Harvey expressed her disappointment in the prospect of a conventional whitewash in the knowledge of the staff's opposition to the establishment of hospitals removed from the area of active military operations. Secretary Stanton favored the location of hospitals in every northern state but concluded that he would perforce be guided by the advice of Surgeon General Hammond. When Mrs. Harvey reported this reaction to President Lincoln, he indicated that General Hammond would not return for 2 months. His own attitude had obviously undergone a distinct change; and he arranged for a further conference with Mrs. Harvey the next morning, after he had had an opportunity to discuss the matter with Stanton.

After seeing his relaxed, receptive mood of the evening before, Mrs. Harvey was ill prepared for Mr. Lincoln's manifest irritability. According to Holland's account, when the President wished she had not come to Washington, she made her plea on highly personal as well as patriotic grounds:

" 'Nothing would have given me greater pleasure, sir: but a keen sense of duty to this Government, justice and mercy to its most loyal supporters, and regard for your honor and position, made me come. The people cannot understand why their husbands, fathers and sons are left to die, when, with proper care and attention, they ought to live, and yet do good service for their country. Mr. Lincoln, I do believe you will yet be grateful for my coming. I do not come to plead for the lives of criminals, nor for the lives of deserters; but I plead for the lives of those who were the first to hasten to the support of this Government, who helped to place you where you are—for men who have done all they could; and now when flesh and nerve and muscle are gone, who still pray for your life, and the life of the republic. They scarcely ask for that for which I plead. They expect to sacrifice their lives for their country. Know that, if they could come North, they could live and be well, strong men again—at least, many of them. I say I know, because I was sick among them last spring, surrounded by every comfort, with the best of care, and determined to get

well. I grew weaker and weaker, day by day, until, not being under military law, my friends brought me North. I recovered entirely by breathing northern air.'"

The forthright candor of this statement and the patent unselfishness of the advocate deeply impressed Mr. Lincoln. Mrs. Harvey brought home the force of her 8 months of service in the regimental and general hospitals along the Mississippi River from Quincy to Vicksburg; she did not spare discussing the President's ultimate responsibility for a policy of medical care and disposition of the Army sick and wounded that was contributing so much to extended morbidity and increased mortality. Mr. Lincoln passed from irritability to personal resentment to depression in the course of this interview. Under the circumstances, Mrs. Harvey was astonished to receive his invitation to a further conference on the morrow. On this occasion the President was most cordial. His quiet announcement, "I only wish to say to you that an order which is equivalent to the granting of a hospital in your State has been issued from the War Department nearly 24 hours," quite overwhelmed Mrs. Harvey. To reassure her, Mr. Lincoln suggested that she return to the White House the next morning to receive a copy of the order in person. On this occasion they discussed the name of the hospital.

*(The final part of Doctor Middleton's paper will be published in the May issue of the Journal.)*

## SPRING SCIENTIFIC SESSION OF THE WISCONSIN SOCIETY OF ANESTHESIOLOGISTS

The spring scientific session of the Wisconsin Society of Anesthesiologists will be held Saturday afternoon and Sunday, May 8 and 9, in Room 300 of the Wisconsin General Hospital in Madison.

### PROGRAM

**Saturday, May 8**

2:00 p.m. Symposium on Cardiovascular Surgery.
Preoperative Pathology and Diagnosis: The Cardiovascular Department
Problems of Refrigeration and Anesthesia: The Anesthesiology Department
Surgical Correction of Cardiac Defects: The Surgical Department

6:30 Informal get-together and dinner. Reservations necessary. Please send to: William H. L. Dornette, M. D., Department of Anesthesiology, University of Wisconsin Hospitals, Madison 6, Wisconsin

**Sunday, May 9**

10:00 a.m. Symposium. Role of the Anesthesiologist in the Care of the Patient with Polio and Tetanus.
O. S. Orth, M. D., Madison, Chairman
F. H. Van Bergen, M. D., St. Paul
Max Sadove, M. D., Chicago
Herman Wirka, M. D., Madison

11:15 Subject to be announced. Albert Faulconer, M. D., Mayo Foundation, Rochester, Minn.

11:45 Three ten-minute presentations by residents dealing with current research topics, each followed by five minutes of discussion

12:30 Luncheon (No formal luncheon planned, but space will be reserved in hospital cafeteria)

2:00 Symposium. Anesthesia and the Poor Risk Patient
Milton Davis, Jr., M. D., Madison, Chairman
John Sims, M. D., Madison
Charles Crumpton, M. D., Madison
Henry Suckle, M. D., Madison

3:15 Pediatric Anesthesia in Everyday Practice. Henry Slater, M. D., Montreal

3:45 Question and Answer Period

# Newer Methods of Diagnosis and Therapy in Office Gynecology*

By JASON H. COLLINS, M. D., HIRAM W. K. BATSON, M. D., and LEWIS I. POST, M. D.
New Orleans

RECENT trends in the diagnosis and treatment of the ambulatory or office patient in gynecology have emphasized the efficacy of the sulfonamides and antibiotics both systemically and topically, more judicious and intelligent use of endocrine products, and the introduction of enzymatic substances for debridement. Diagnostically, the great emphasis placed on cytology, while it is controversial, has at least reawakened the physician, as well as the patient, to the necessity and value of periodic, complete pelvic examination, including visualization of the vagina and cervix. The use of culdocentesis is now an accepted procedure and an invaluable aid to the office evaluation of the many pelvic diseases.

Much has been written on all these subjects. We have had a unique opportunity on the Tulane service at Charity Hospital to observe a large number of patients with pelvic abscesses or eccyesis, thus enabling us to evaluate culdocentesis. Beacham's report in 1948 emphasized our feeling as to the value of culdocentesis as a diagnostic procedure. Culdocentesis, which originally was performed only on "in" patients, is now in frequent use in the outpatient departments at Charity Hospital on all three services. It is used by most gynecologists in our area as an office procedure in their private work.

Culdocentesis is employed by us to determine the type of fluid present in the cul-de-sac. We have found that there are no characteristic findings in palpation, inspection, etc., to differentiate between blood, acitic fluid, or pus in the pouch of Douglas. By employing a needle and aspirating, we can immediately determine which is present and proceed with further diagnostic evaluations relative to the primary pathology present.

*From the Department of Obstetrics and Gynecology, Tulane University of Louisiana, School of Medicine, and the Division of Obstetrics and Gynecology, Tulane Unit, Charity Hospital of Louisiana at New Orleans.

Presented at the One Hundred and Twelfth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 7, 1953.

### Technic of Culdocentesis

When diagnosis of a case is in doubt, the patient is placed in the lithotomy position. After thorough abdominal and pelvic examinations have been done, the vagina is cleansed and prepared with a surface antiseptic. A tenaculum is placed on the posterior lip of the cervix and traction is made in the long axis of the vagina, with a slight elevation of the handles of the tenaculum to effect an anterior displacement of the cervix and thereby expose the posterior fornix of the vagina. An 18-gauge, long spinal needle is then introduced in the mid-line of the vagina about one cm. posterior to the cervix and pushed cephalad about 2 cm. into the cul-de-sac or mass present. As the needle pierces the peritoneum, the patient experiences momentary pain. (Local anesthetic may be used but is generally unnecessary). A syringe is then attached, and aspiration is attempted. Most often a single tap is sufficient. If not satisfactory, we do not hesitate to *withdraw the needle* and repeat the procedure. Once the needle is introduced, it is held steady and not allowed to wander or be pushed in any other axis. In fact, a second or third puncture is always done if the first does not provide fluid for evaluation.

Three general types of fluid may be obtained by aspiration. These are peritoneal, blood, or pus (or a combination thereof). Clear peritoneal fluid, which grossly is not diagnostic of any particular disease entity, may be of value as a negative finding if one has suspected blood or pus. Study of this fluid by laboratory methods of microscopy or bacteriology may be diagnostic in some cases of intraperitoneal malignancy or infection.

Blood-tinged fluid may be found in unruptured ectopic pregnancy or malignancies or may simply represent an artifact. When obtained, repetition of the culdocentesis is usually done after an interval of some hours or days, dependent upon subsequent general findings in the patient's progress.

Slightly purulent or cloudy peritoneal fluid may be found in patients with cysts, salpingitis, appendicitis, pelvic peritonitis, or neoplastic or inflammatory process in the abdomen. These patients are subsequently evaluated by other clinical and laboratory methods. Smears and cultures of this type fluid are frequently of value in specifying the organism or organisms with which one is dealing and can be of value in the choice of the therapeutic drug employed, as well as being utilized for sensitivity studies.

### Blood

When blood is withdrawn, it usually indicates hemoperitoneum. The only exception to this diagnosis is when the needle directly enters a blood vessel. When the latter has occurred, the blood obtained is usually bright red and clots. In hemoperitoneum, the blood is generally of a darker hue, may contain small flecks of old clots, and fails to coagulate when emptied from the syringe. It must be emphasized that the presence of particles of old clots is as diagnostic of hemoperitoneum as failure of the blood to coagulate after aspiration.

We are convinced that the employment of this procedure without hesitation by our house staff at Charity Hospital in the admitting room, out-patient clinic, and the wards has contributed inestimably to the remarkable reduction of the mortality rate from eccyesis on our service in the past 15 years. From 1919 to 1936, there were 51 deaths at Charity Hospital due to ectopic pregnancy, with an uncorrected mortality rate of 11.4 per cent. From January 1, 1937, through December 31, 1950, there were 18 deaths, giving an uncorrected mortality of 2.6 per cent. Undoubtedly, the improved physical plant, the residency system instituted in 1937, the improved anesthesia service, and the blood bank all contributed to this excellent reduction. In the period of January 1, 1951, through July 1, 1953, with essentially the same facilities, but with much wider application of culdocentesis, the mortality rate in *255* cases of eccyesis was 0.38 per cent. Of these cases 133 were on the Tulane service, with *no* fatalities.

The other findings, as indicated by the chart, reveal that only a small number of cases with hemoperitoneum were from other causes but that the majority of these were opened because the "positive" cul-de-sac puncture required surgical intervention for preservation of life.

### Pus

Aspiration of pus indicates peritonitis, pelvic abscess, or both. The aspiration of pus from a circumscribed mass may seem superfluous diagnostically when other clinical findings have indicated infection. Our opinion is to the contrary. Clinical findings of hyperthermia, pelvic peritoneal irritation, and pelvic mass usually indicate an abscess but may occur from a twisted adnexal neoplasm, degenerating fibroid, or an old walled-off ectopic gestation. Aspiration of pus from the mass will establish a definite diagnosis. In addition, bacteriological studies of the purulent material obtained are of value in the choice of therapeutic agents or methods. *The diagnostic aspiration of pus from the cul-de-sac of a patient with the history and signs of a sudden abdominal catastrophe suggestive of ruptured pelvic abscess may mean the difference between survival and death.* Such a finding on culdocentesis on our service immediately categorizes such a patient as a dire surgical emergency. Immediate surgical intervention in this type case in the past 2 years has reduced the mortality rate from ruptured pelvic abscess on our service from 60 per cent to 10 per cent. We attribute much of our success in these cases to the rapidity with which the diagnosis can be established by culdocentesis.

### Other Fluids

Aspiration of the cul-de-sac in the presence of solid or cystic pelvic tumors may be performed. The peritoneal fluid thus obtained can be studied cytologically. By this method one may be enabled to diagnose intra-abdominal malignancy preoperatively. Direct aspiration of a cystic mass strongly suspected as malignant is not encouraged, as the danger of seeding an otherwise free peritoneum is a real one.

A few of us utilize the procedure in the office postoperative examination of patients who have masses in the region of the cuff following hysterectomy. If hematoma alone is suspected, it is not invaded; but if an ovarian cyst that is considered a postoperative development is present, a single aspiration may be sufficient to relieve symptoms and effect cure. It is worth mentioning here that culdocentesis is of value in determining postoperative intra-abdominal bleeding. In

CULDOCENTESIS DONE ON TULANE SERVICE AT CHARITY HOSPITAL OF NEW ORLEANS FROM JULY 1, 1953, TO SEPTEMBER 9, 1953 (10–WEEK PERIOD)

| | July | | | | | | August | | | | | | September 1–9 inclusive | | | | | | 10-Week Totals | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Clinic | | Admitting Room | | Total | | Clinic | | Admitting Room | | Total | | Clinic | | Admitting Room | | Total | | | | Grand Total |
| | Colored | White | Colored | White | Colored | White | Colored | White | Colored | White | Colored | White | Colored | White | Colored | White | Colored | White | Colored | White | |
| Patients Seen | 822 | 302 | 120 | 35 | 942 | 337 | 910 | 331 | 99 | 32 | 1009 | 363 | 110 | 85 | 20 | 7 | 130 | 92 | 2081 | 792 | 2873 |
| Patients Who Had Culdocentesis | 26 | 3 | 36 | 6 | 62 | 9 | 40 | 6 | 31 | 8 | 71 | 14 | 7 | 1 | 3 | 3 | 10 | 4 | 143 | 27 | 170 |
| Total Number of Single "Taps" | 37 | 8 | 80 | 11 | 117 | 19 | 50 | 6 | 82 | 21 | 132 | 27 | 7 | 1 | 7 | 5 | 14 | 6 | 263 | 52 | 315 |
| Number of Patients with Contents of Cul-De-Sac as Follows: Unclotted Blood | 0 | 0 | 3 | 0 | 3 | 0 | 3 | 1 | 2 | 0 | 5 | 1 | 0 | 0 | 0 | 2 | 0 | 2 | 8 | 3 | 11 |
| Clotted Blood | 1 | 1 | 2 | 1 | 3 | 2 | 2 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 2 | 7 |
| Pus | 2* | 0 | 5 | 2 | 7 | 2 | 0 | 0 | 4 | 1 | 4 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 11 | 3 | 14 |
| Peritoneal Fluid | 19 | 1 | 24 | 3 | 43 | 4 | 27 | 3 | 18 | 5 | 45 | 8 | 6 | 1 | 2 | 0 | 8 | 1 | 96 | 13 | 109 |
| Dry | 4 | 1 | 2 | 0 | 6 | 1 | 8 | 2 | 7 | 2 | 15 | 4 | 1 | 0 | 1 | 1 | 2 | 1 | 23 | 6 | 29 |
| Number of Patients with Ectopic Pregnancy Confirmed by Surgery | ---- | ---- | ---- | ---- | 2 | 0 | ---- | ---- | ---- | ---- | 5 | 1 | ---- | ---- | ---- | ---- | 0 | 0 | 7 | 1 | 8 |
| Number of Patients with "Positive Culdocentesis" Who Had Laparotomy with: Postoperative Diagnosis: Threatened Abortion | ---- | ---- | ---- | ---- | 1 | 0 | ---- | ---- | ---- | ---- | 0 | 0 | ---- | ---- | ---- | ---- | 0 | 1 | 1 | 1 | 2 |
| Postoperative Diagnosis: Bleeding Corpus Hemorrhagicum | ---- | ---- | ---- | ---- | ---- | ---- | ---- | ---- | ---- | ---- | ---- | ---- | ---- | ---- | ---- | ---- | ---- | 1 | ---- | 1 | 1 |

*Includes 1 dermoid fluid.

this situation, one should be careful in estimating the amount of blood that can be withdrawn as a necessary part of the evaluation. Most postlaparotomy or postvaginal hysterectomy patients will have some blood intraperitoneally. It is in the case of clinical evidence of decreasing blood volume, with the easy withdrawal of a large amount of blood from the cul-de-sac, that surgical intervention is warranted. Corrective surgery can usually be done sooner by the utilization of culdocentesis than by awaiting characteristic changes in the blood pressure, pulse, or hematocrit.

## Complications

Culdocentesis is not foolproof. We believe that complications *per se* are rare. We have no record of any patient suffering sequelae from the procedure itself. We know that the bowel, either large or small, is occasionally entered; but there are no recorded instances at Charity Hospital of fistulae or pelvic abscesses developing as a result of this complication. We have had occasions when blood was withdrawn from the cul-de-sac. This and other clinical symptoms led to laparotomy in a number of instances wherein surgery was unnecessary; but the recent review of culdocentesis by Beacham *et al.* showed these to be a small percentage of cases.

The following is a preliminary report on a statistical study, under direction of one of us (L. P.), being done on our service for the current year. It is entered here to emphasize our opinion of the value of culdocentesis. For the 10-week period subsequent to July 1, 1953, 2,873 patients (2,081 colored and 792 white) were seen on the Tulane service at Charity Hospital of Louisiana at New Orleans in the clinics and admitting rooms. Of these, 170 patients (143 colored and 27 white) had culdocentesis. That is to say, for every 17 patients seen, 1 had a culdocentesis. The total number of single "taps" done was 315, which means that each patient had an average of 2 cul-de-sac aspirations. These were not indiscriminately selected patients, but they were patients who presented signs or symptoms which, according to our criteria, prompted the cul-de-sac punctures. Thus, the latter were done either to make a diagnosis or to confirm one. (See chart).

Of the 11 patients (6.5 per cent) who had unclotted blood on cul-de-sac tap; *i.e.*, a "positive" tap, 8 patients had ectopic pregnancies, confirmed by immediate laparotomy. This represents an accuracy of 72.7 per cent for the 10-week period but, in our experience, is lower than our yearly accuracy, which is an estimated 90 per cent. Two patients (who had a history of pelvic pain, a recently missed menstrual period, aberrant uterine bleeding, an apparently normal-sized uterus, and unclotted blood on culdocentesis) had laparotomy, revealing a small amount of blood in the pouch of Douglas from retrograde tubal flow; an early pregnancy was noted and a diagnosis of threatened abortion was made. One patient who desired a private physician was operated upon at another hospital and had a bleeding corpus hemorrhagicum, with 500 cc. unclotted blood in the abdomen. There were no fatalities in any of the above cases.

Of the 14 patients (8.2 per cent) who had pus on culdocentesis, 9 had tubo-ovarian abscesses (2 had ruptured and 7 were intact); 2 had pelvic peritonitis; 1 had acute salpingo-oophoritis; 1 had an old pyosalpinx, asymptomatic; and 1 had a multilocular ovarian cyst with fluid therein resembling dermoid fluid. All these patients were treated medically or surgically, and there were no fatalities.

Of the 7 patients (4.1 per cent) who had clotted blood on cul-de-sac puncture, all were interpreted as negative in the light of the history and physical examination, the patients having such diagnoses as postoperative cuff hematoma, fibroids, pyelitis of pregnancy, threatened abortion, etc.

One hundred nine patients (64.1 per cent) had clear peritoneal fluid revealed on culdocentesis, which was considered as normal.

Twenty-nine patients (17.1 per cent) had no fluid obtainable on aspiration of the cul-de-sac and were listed as "dry."

It is noteworthy in summary that following the 315 "single taps" of the 170 patients who had culdocenteses during this 10-week interval, there were to date no verbal or recorded complications in any of these patients due to the cul-de-sac puncture.[1-6]

### Therapeutic Aids

We have been using cortisone in a number of clinical conditions. Since 1951, a group of patients manifesting the findings of ligneous cellulitis have responded to cortisone where other measures failed. Ligneous pelvic cellulitis is a chronic condition of the pelvic tissues characterized by induration, tenderness, firmness, and fixation. Histologically, the tissue reveals marked inflammatory reaction, with cellular infiltration, edema, and varying degrees of fibrosis. This form of cellulitis is usually due to streptococcal invasion of the pelvic tissues and lymphatics. This most frequently follows instrumentation of the pregnant uterus but also follows any number of types of pelvic manipulations.

In addition to the beneficial effects noted in ligneous cellulitis, we have noted that cortisone softens radiation fibrosis or inflammatory reactions around pelvic malignancies that have been radiated. This inflammatory reaction or fibrosis frequently is of such extent and of such character that misinterpretation of recurrence or spread of malignancy may result at follow-up examination. Cortisone, given in divided doses over a 10 to 12 day period until a total of 1 Gm. has been administered, softens the nonmalignant tissues and enables the examiner to differentiate and to determine the true status of the patient.

The use of cortisone as an adjunct to therapy in the treatment of nonmalignant, nontuberculous, granulomatous lesions of the genital tract is under investigation by our department. The number of cases to date are too few for evaluation, but we have been encouraged by our results to continue this investigation.[7,8]

### Streptokinase and Streptodornase

Streptokinase and streptodornase are used for medical debridement in a variety of conditions such as superficial wound infections, pilonidal cysts, burns, pyothorax, and hemothorax. Since July 1, 1951, the Tulane gynecological service at Charity Hospital has been utilizing these substances in pelvic abscesses with the idea of decreasing the viscosity of the purulent material, allowing more complete drainage, and perhaps eliminating definitive surgery, such as total hysterectomy with or without bilateral salpingo-oophorectomy.

The results of our study revealed that Varidase* (streptokinase and streptodornase) was changing the character of the

*Lederle streptokinase and streptodornase.

fluid mainly by decreasing its viscosity. This was measured by using an ordinary test tube with a standard column of fluid, an 18 gauge spinal needle as airway, and a 20 gauge needle through which the rate of flow was measured. The difference in the rate of flow of the fluid obtained at the time of diagnostic cul-de-sac puncture, before Varidase was injected, and that of the fluid obtained 24 hours later by aspiration or colpotomy indicated the change in viscosity.[9,10]

Our method of using Varidase is as follows: At the time of diagnostic puncture, at least 10 cc. of the abscess fluid is withdrawn. One ampoule of Varidase solution in 10 cc. of normal saline is then injected through the same needle into the cavity. It is emphasized that more pus must be withdrawn than the amount of solution to be injected so that rupture of the abscess may be avoided. Twenty-four hours later the abscess, if small, is aspirated; if large, a colpotomy is performed. For four days thereafter, one injection daily through the colpotomy tube usually suffices.

It is obvious that all the aforementioned could not be done in the office; but small abscesses, postoperative cuff abscesses or Bartholin's gland abscesses can be so managed.

Response to antibiotic treatment is thus better assured, and cure is hastened. This study is still under evaluation.

### Kegel's Exercises

In 1948, Kegel described perineal exercises for urinary stress incontinence resulting from relaxation of the pelvic floor. His method proved that voluntary control of the various divisions of the levator muscle and of the muscle fibers of the pelvic fascia exists. As advocated and with proper instruction, the majority of patients may correct the relaxation, whether secondary to atrophy or to the trauma of childbirth. Excellent results have been reported in the correction of symptomatic cystocele and rectocele. In conjunction with this type therapy, it is important to treat other contributory lesions of the bladder such as trigonitis and urethritis. If cervicitis is present, it should also be corrected. While we are unable to provide statistical proof, our clinical evaluation of this form of therapy is excellent. Seldom do we find it necessary to operate primarily for stress incontinence in the otherwise uncomplicated case if the patient can learn the exercises.

In addition, we find that routine training of pubococcygeal muscle control in the postpartum patient reduces the number of instances of pelvic relaxation. We also find that pre- and postoperative pubococcygeal exercise has given us better results in such procedure as vaginal hysterectomy, anterior and posterior colporrhaphy, and the repair of fistulae or third degree tears. One finds at operation that the "tissue" planes are better formed and easier to dissect and suture. These beneficial effects are enhanced by the judicious pre- and postoperative use of topical estrogens intravaginally. The value of this therapy is entirely dependent upon the patient's ability to learn to contract her pubococcygeus muscle. This physiological method to correct genital muscle relaxation is divided into two phases or steps: (1) specific muscle education and (2) resistive exercises of the pubococcygeus and its visceral extensions. The reader is referred to the excellent discussion of the methods by Kegel.[11-14]

### Summary

We have presented one diagnostic method which, while not new or recent, has, we feel been insufficiently popularized in this country. Culdocentesis in our clinics, admitting rooms, and private offices is considered an invaluable aid in the diagnosis of several gynecological disease entities. We are constantly broadening its application and are impressed with the fact that we have not encountered any complication or deleterious effect attributable to its performance. We know that its use has saved many lives on our service in the past 15 years.

Streptokinase and streptodornase are being employed in an investigation in a series of gynecological disease entities. Their use in debridement of wounds and as an aid in pelvic abscess evacuation is proved. Their further application in office procedures is under study.

Cortisone is used in a host of diseases and disease entities. It is of greatest value to us as an aid to medical management of some forms of chronic pelvic cellulitis, as a preoperative measure in ligneous cellulitis so that surgery may be avoided or facilitated, and as a means of evaluating the clinical extent of radiation-treated malignancies of the pelvis during the follow-up period.

Voluntary exercises of the pubococcygeus muscle have proved to be an efficacious measure on our service. Their use in routine postpartum care, as well as pre- and postoperatively in vaginal surgery, is stressed. We regard Kegel's investigation in this physiological approach to a major gynecological problem an outstanding contribution.

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## 1953–54 SCHOLARSHIPS AVAILABLE IN PLASTIC AND RECONSTRUCTIVE SURGERY

The Foundation of the American Society of Plastic and Reconstructive Surgery announces the regulations of the Fifth Annual Scholarship Contest:

1. The contest in Junior Classification is restricted to residents in training and to plastic surgeons who have been in practice no longer than five years.
2. Two main prizes are offered, each consisting of a three-months' plastic surgery scholarship with full maintenance in a number of selected leading services, in the United States and abroad.
3. The subject matter of the essay must be the result of some original research (either clinical or experimental) in the field of plastic and reconstructive surgery. The thesis should be of about 5,000 words, and written in English.
4. Work previously published wholly or in part is not acceptable.
5. Expenses of travel between the services will be allotted.
6. A silver plaque or a certificate of honorable mention is also offered for a winning essay in Senior Classification to contestants active in practice of plastic and reconstructive surgery for more than five years.
7. Manuscripts will not be accepted by the Award Committee after July 1, 1954.
8. The winning essays will be presented in person at a formal program of the Foundation of the American Society of Plastic and Reconstructive Surgery to be held in the fall of 1954.

For further information, write to the Award Committee, % Jacques W. Maliniac, M.D., Chairman, 30 Central Park South, New York, N. Y.

# Testicular Tumors*

By KENNETH O. GHORMLEY, M. D., and JAMES L. JAECK, M. D.**
La Crosse

THIS seminar presents a simple, practical classification of testicular neoplasms, emphasizes clinical and laboratory findings useful in diagnosis, and seeks to establish the independence of the seminoma. In practice, all tumors of the testis should be regarded as malignant until proved otherwise. The family doctor, not the specialist, sees these tumors first and should be prepared to advise the patient intelligently regarding prompt diagnosis and treatment.

## Etiology

The etiology of testicular tumors is unknown. Trauma probably only attracts attention to the already existing tumor. Increased size of the tumor-bearing testicle may make it more vulnerable. Relationship to cryptorchidism is debatable. An American Urological Association poll showed a negligible increase of malignancy in undescended or ectopic testes. In the Army series of Friedman and Moore, however, there was a greatly increased incidence of malignancy in cryptorchids and a predilection for seminoma in this group.[1] The possibility of malignancy in undescended testes should not alone be indication for orchidectomy.

## Incidence

Testicular tumors comprise about 2 per cent of all cancer in men and about 5 per cent of malignancies of the genitourinary tract.[2] They are, however, the *most common* malignant tumor of young men between 25 and 30.[3]

## Embryogenesis and Homologous Ovarian Tumors

About 97 per cent of testicular tumors are germinal and 3 per cent non-germinal.[4] Germinal tumors arise from the germinal epithelium of the testis. It is thought that an undifferentiated germinal cell, by embryological error, becomes incorporated by the developing gonad and remains as a multipotent, aberrant sex cell capable of neoplastic development in several histologic directions.[5] We will not concern ourselves here with the rare tumors arising from non-germinal elements of the testis.

All of the germinal tumors of the testis have their homologue in the ovary; for example, seminoma testis—dysgerminoma ovary. Other than in histologic type, there are few analogies that can be drawn between testis and ovary. For example, there are many *benign* ovarian tumors, but the testis favors undifferentiated *malignant* growth.[2]

## Classification

The classification proposed below seems logical, practical, and is in agreement, except for terminology, with that of Friedman and Moore.[1] We wish to point out and emphasize the independence of the seminoma from all other germinal tumors of the testis, particularly the teratoid group.

TABLE 1

| Our Classification (after Broders') | Incidence average for all age groups | Classification of Friedman and Moore—Army series | Incidence (Army series) |
|---|---|---|---|
| I SEMINOMA | 55% | I SEMINOMA (pure) | 35% |
| II TERATOID TUMORS | 41% | | 61% |
| (a) Dermoids and epidermoid cysts | 1% (benign) | | 1% (benign) |
| (b) Teratoma, adult type | 5% (benign) | III TERATOMA, (pure or with I) | 6% |
| (c) Monodermal teratoma | 20% | II EMBRYONAL CARCINOMA (pure or with I) | 19% |
| (d) Malignant teratoma | 15% | IV TERATOMA (with II, V, or both, with or without I) | 35% |
| (e) Chorioepithelioma (pure) | 0.4% | V CHORIOCARCINOMA (pure, or with I or II, or both) | 0.4% |
| III INTERSTITIAL-CELL TUMORS | 1% | | 1% |
| IV MISCELLANEOUS TUMORS | 3% | | 3% |

The younger age group in the army series accounts for the 20 per cent lower incidence of seminoma, and the 20 per cent higher incidence of malignant teratoma. Seminomas, then, comprise about 60 per cent and teratoid tumors about 40 per cent of testicular neoplasms. Distinguishing the seminoma

*Abstracted clinical-laboratory seminar of the Gundersen Clinic, La Crosse. The full-length seminar is available on request.

**Doctor Ghormley is in the department of urology, Gundersen Clinic; Doctor Jaeck is pathologist and director of laboratories, Gundersen Clinic and La Crosse Lutheran Hospital.

(clinically and pathologically) from all other malignant testicular tumors is of prime importance for prognosis and treatment.

TABLE 2.—*Contrasting Features of Seminomas vs. Malignant Teratoid Tumors*

| Characteristics | Seminoma | Teratoid Tumors |
|---|---|---|
| Age | 40–45. Rare before 20. | 30–35. Not unusual in childhood. |
| Behavior | Slow growth—late invasion (years). | Rapid growth—early invasion (months). |
| Gross Appearance | Usually large but shape of testis preserved.<br>Firm, homogeneous, white or gray, and cut surfaces bulge.<br>Necrosis—late.<br>Hemorrhagic—rarely. | Variable size but irregular shape and distort shape of testis.<br>Cystic or solid, multicolored, heterogeneous.<br>Necrosis—usual.<br>Hemorrhagic—often (choriocarcinoma). |
| Radiosensitivity | Excellent. | Radioresistant. |
| Metastases | Late—lymphatic. | Early—lymphatic and hematogenous. |
| Prognosis | Good. | Poor to hopeless. |

## Tissue Pathology and Diagnosis

*Biopsy.* For diagnosis of tumor type, biopsy of the testis is to be condemned. Overlapping of histologic types is notorious in testicular tumors. The tumor behaves like its *most malignant* component, so the false security of a histologically benign random biopsy might be tragic. There is a good chance of missing tumor altogether by biopsy.

**Seminoma, testis. Note discrete spherical tumor nodules replacing one third of testis. Soft, bulging, grayish-white homogeneous tumor mass with few small foci of necrosis. Illustration is 1.2 x actual size. Testis with tumor was 12 x 6 x 6.5 cm.**

*Grading.* Nothing is accomplished by grading testicular tumors, and it is a hazardous practice for any pathologist to engage in. Most important for the pathologist is to cut multiple blocks from every tumor in the testis before making his final diagnosis. The diagnosis of "benign adult teratoma" is a hazardous pathologic diagnosis.

*Histopathology.* There is usually no difficulty in placing the tumor in one of the histologic groups (Table 1) if the pathologist has the entire tumor and/or testis, and has cut multiple sections from all parts. In our opinion the microscopic diagnosis should be based on the most malignant cell type found, rather than on the predominant cytologic or histologic pattern. A small focus of carcinomatous tissue in a "pure seminoma" might be missed by even the most careful study; but fortunately, the majority of seminomas are "pure."

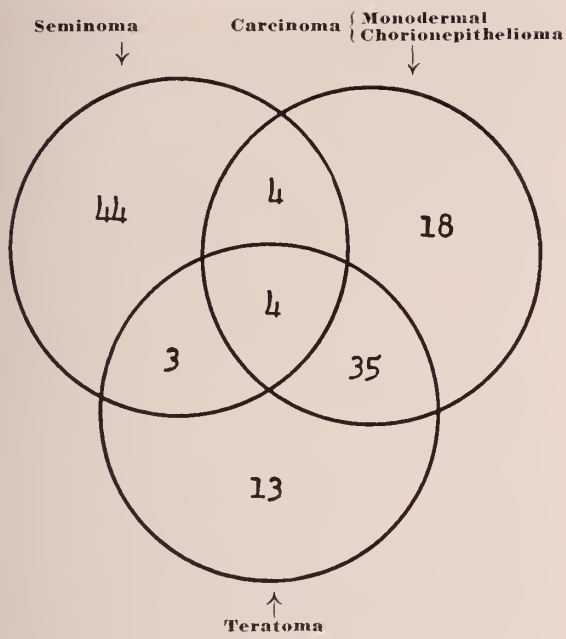
The seminoma and monodermal teratoma (embryonal carcinoma) are the only tumors requiring careful histologic differentiation.

TABLE 3

| Histologic Feature | Seminoma | Monodermal Teratoma |
|---|---|---|
| General Pattern | Monotonous, regular, usually consistent. | Complex, undifferentiated, variable. |
| Cells | Large, round or polyhedral.<br>Distinct cell borders.<br>Clear cytoplasm.<br>Closely packed tumor cells. | Large, pleomorphic, anaplastic.<br>Indistinct cell borders.<br>Homogeneous cytoplasm.<br>Loose, closely packed—may show glandular or papillary structures. |
| Nuclei | Large, hyperchromatic, round, central.<br>Prominent nucleoli.<br>Rare mitotic figures. | Large, irregular, bizarre.<br>Light chromatin pattern.<br>Nucleoli usually present.<br>Many mitotic figures. |
| Stroma | Lymphoid, granulomatous or scirrhous.<br>Trabeculation and lobulation. | No consistent stromal pattern. |
| Necrosis | Focal "ischemic necrosis"—ghost tumor pattern remains. | "Hemorrhagic necrosis"—tumor pattern wiped out. |

The other testicular tumors have quite diagnostic features and are not apt to be confused with the seminomas. The "adult teratoma" group shows a chaotic array of undifferentiated tissues, either fetal or adult, often with an organoid pattern. The malignant teratoma group is teratoma plus monodermal teratoma (embryonal carcinoma) or choriocarcinoma or both. Choriocarcinoma is easily identified by finding the typical syncytial-trophoblastic tissue. The syncytial cells stand out as large multinucleated cells with deeply eosinophilic cytoplasm. One may see villus structures resembling chorionic villi of the placenta.

Moon[6] has shown the overlapping of the teratoid tumors of the testis by the following diagram, based on a study of 200 tumors.




Using the same diagram, Moon charted 26 deaths after 2½ years follow-up. As others, he concluded that the monodermal teratoma (embryonal carcinoma) and choriocarcinoma are the real killers among testicular tumors. We are again reminded of the independence of the seminoma.

When seminoma is associated with one of the teratoid group of tumors in the same testis, it is not intermingled, but occurs as distinct, separate, often satellite nodules suggesting origin secondary and independent of the pre-existing tumor.

The Army series drew two conclusions relative to histologic type:

1. Pure seminoma is much less malignant than any of the teratoid group, but when mixed with other types, it does not influence the course of the more malignant component.

2. Whenever teratoma coexists with embryonal carcinoma or choriocarcinoma or both, the extremely malignant behavior of the latter two is definitely lessened.

In the seminoma category, two histologic features have prognostic significance. Seminomas showing a lymphoid stroma had only one-third the mortality rate of those without lymphoid stroma. Vascular invasion by tumor increased the mortality of seminoma about 3 times.[1]

In all tumor groups, hyperplasia of the interstitial cells of the testis correlated with a poor prognosis.[1]

### Metastases

The presence or absence of demonstrable metastases at first examination is most significant in prognosis. The lumbar periaortic and iliac nodes are the first involved for all tumor types.[7] Inguinal nodes are involved only when tumor has extended to the scrotum.[8] The lungs are the most common site of hematogenous metastases. There is no relation between *size* of primary tumor and extension or metastatic spread.[1] Teratoid tumors show a higher incidence of metastases on first examination than do seminomas.[1]

### Mortality and Survival Rate

Cabot and Berkson,[9] reporting 363 patients, found a 70 per cent 5-year survival rate for seminoma and a 30 per cent survival rate for teratoid tumors. Friedman and Moore's Army series showed a 32 per cent 2-year mortality for seminomas which had metastases on first examination.[1] Monodermal teratomas had a 59 per cent, malignant teratomas an 84 per cent, and chorioepitheliomas a 100 per cent 2-year mortality (in cases showing metastases on first examination)[1] in their series.

### Gonadotropic Hormone Tests

*Biochemistry.* The specific hormonal assay pertinent in the diagnosis of testicular tumors is *chorionic* gonadotropic hormone.[10] The pituitary gonadotropic hormones of our normal physiology have two components—F.S.H. (follicle-stimulating hormone), which stimulates spermatogenesis in the male, and L.H. (luteinizing hormone), which stimulates the Leydig cells of the testis to produce male sex hormone (androgen).

Chorionic gonadotropin is produced only by chorionic epithelial cells,[11] occurring in the following situations:

(a) Trophoblastic and placental tissue (pregnancy).
(b) Placental neoplasms.
(c) Testicular tumors, especially chorionepitheliomas.

*Urinary Gonadotropic Hormone Assay.* Confusion has prevailed because of poor standardization of methods, lack of uniformity in reporting, over-interpretation, and failure to distinguish pituitary and chorionic gonadotropins.

Qualitative methods are simply "pregnancy tests" dependent on increased urinary

excretion of gonadotropic hormones. Early, the hormone titre of a testicular tumor may not be high enough to give a positive test.

Quantitative determination of chorionic gonadotropins is a tedious biologic assay, requiring precipitation and extraction technics. Heat and standing affect the potency of the hormone in the urine specimen.

Semiquantitative methods are most used. Immature female mice receive sub-Q injections of patient's urine in graduated amounts. Ninety-six hours later, they are killed and ovaries and uterus examined for increased size and weight, vascularity, hemorrhagic follicles, and corpora lutea. Gross and microscopic findings should check. Results are reported in m.u. (mouse unit) per liter or per 24-hour specimen. In our laboratory only *marked increases* in gonadotropin (up to 10,000 m.u. per 24 hours) are considered significant relative to testicular tumors. Such levels correlate well with the presence of a testicular malignant tumor —usually chorionepithelioma. Assay levels in seminomas should be normal or nearly so. I feel any other interpretation of the test is dangerous and inconsistent.

Pre- and postoperative levels give more information than a single determination. A sudden sharp rise in gonadotropin level may indicate metastases. False positives are rare using the above criteria for interpretation.

*Directions for urinary gonadotropic hormone assay.*

1. First a.m. urine specimen.
2. No medication 24 hours preceding test.
3. Fresh urine specimen to laboratory specifically requesting urinary gonadotropin assay and not simply A–Z or pregnancy test.
4. Laboratory will send specimen to a good endocrine laboratory equipped for biologic assay.

### Treatment

The three currently accepted methods of treatment are:

1. Orchidectomy.
2. Orchidectomy with radiation.
3. Orchidectomy, radiation, and radical surgery.

Orchidectomy should include ligation of the spermatic cord at the internal inguinal ring. Orchidectomy with radiation is the treatment of choice for seminoma. Leddy[12] suggests a total dose of 540 r. to each of 10 fields, repeated in one month. Many feel this dose is too conservative. Lewis[13] is the chief advocate of radical operation. Radical surgery includes orchidectomy and radical retroperitoneal node dissection (all nodes and fat from Poupart's ligament to the renal pedicle). Pre-operative radiation accomplishes little and wastes precious time. With radiation, approximately 80 per cent 5-year survivals are possible for seminomas.

### Summary

1. A simple classification of testicular tumors is presented.
2. The independence of the seminoma is emphasized.
3. The gonadotropic hormone assay is evaluated.
4. Pathology of testicular tumors is reviewed.
5. Favorable prognostic signs are no pain in testis, negative urinary gonadotropin, no metastases on first examination, no extension outside testis, no vascular invasion, and no hyperplasia of interstitial cells.
6. Insignificant factors for all tumors of the testis are size of tumor and duration of symptoms before treatment.

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# Accidental Rupture of a Dermoid Cyst During Surgical Excision*

By J. R. EVRARD, M. D., and L. J. SCHNEEBERGER, M. D.
Milwaukee

RUPTURE of a dermoid cyst is a rare occurrence. Kistner, in 1952, reviewed the literature and found 22 cases, including 2 of his own. None of these ruptures took place during surgical excision. The thick capsule and well defined pedicle associated with a dermoid cyst[1] usually render surgical removal a rather simple procedure. In the case to be presented, a previous pelvic inflammatory disease had produced multiple adhesions between the various pelvic viscera. Undoubtedly, this was a contributing factor in the accidental rupture during removal.

## Case Report

The patient was a 43-year-old gravida 0, para 0 who entered the hospital on February 22, 1950, with a chief complaint of irregular vaginal bleeding of 6 months' duration. Her previous menstrual history was uneventful. In the past 6 months, vaginal bleeding had occurred every few days and on one occasion had lasted for a month. The past history and family history were noncontributory except for an episode of pelvic inflammatory disease about a year previously. This apparently had responded to antiobiotic therapy. A physical examination was entirely negative except for the pelvic examination, which revealed a fixed, round mass, 7 cm. in diameter, in the right adnexa. The uterus was normal in size, shape, and in anterior position; and the cervix was clean. The hemogram and the urine examination findings were within normal limits.

On February 23, 1950, laparotomy was performed under general anesthesia. The mass, apparently ovarian in origin, was found between the leaves of the right broad ligament. The broad ligament was opened and the mass carefully dissected from the surrounding tissues. As the base of the mass was being dissected, it ruptured, soiling the pelvic contents with a greasy, yellowish-white material containing hair. The pelvic cavity was cleansed and the cyst wall removed. Pathological examination confirmed the clinical impression of dermoid cyst.

Postoperatively, the patient had a low-grade fever for 10 days and complained of severe low abdominal pain. On the seventh postoperative day, the abdomen became distended. Gastrointestinal suction and intravenous fluid therapy were effective in relieving the distention, and the patient was sent home on the twelfth postoperative day.

On March 17, 22 days after the operation, the patient was readmitted to the hospital with abdominal pain, abdominal distention, and lack of bowel movement for 6 days. Physical examination revealed a woman who was moderately ill but in a fair state of hydration. Her temperature was 99 F., there was marked distention and tenderness of the abdomen, and the bowel sounds were hyperactive. The hemogram showed a red blood cell count of 3,900,000, with 81 per cent hemoglobin, and a 6,200 white blood cell count, with 7 per cent stabs, 70 per cent segmented forms, 17 per cent lymphocytes, and 6 per cent monocytes. The nonprotein nitrogen was 43 mg. per cent, the blood chlorides were 500 mg. per cent, and the plasma proteins and A/G ratio were within normal limits. The diagnosis of mechanical bowel obstruction was confirmed by x-ray. Treatment with a Harris tube, intravenous fluids, and Aureomycin yielded results; and in 2 days the suction was removed. The patient went home on March 25.

The patient again entered the hospital on April 5, with complaints and physical findings as on the previous visit. She responded to gastrointestinal suction and supportive fluid therapy and was discharged on April 12.

Her fourth admission to the hospital was on April 21, and she again had signs and symptoms of mechanical bowel obstruction. Laboratory work, including a hemogram; urine analysis; determination of nonprotein nitrogen, blood chlorides, and blood protein, showed findings within normal limits. Laparotomy to relieve the obstruction was per-

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formed on April 21, 1950. Upon opening the abdomen, dense adhesions between various loops of the bowel and the parietal peritoneum were encountered. Small pockets of fluid were found between the loops of the bowel. Portions of the omentum appeared deep reddish, and the bowel was covered by a violaceous exudate. Biopsy was performed, but the adhesions were so dense and so numerous that it was impossible to free the bowel. Microscopic examination revealed granulation tissue infiltrated with lymphocytes and neutrophils. The diagnosis of fibroplastic peritonitis was made.

Subsequent to surgery the patient began developing ascitis; and on May 11, 1950, it was necessary to perform an abdominal paracentesis, which yielded 6,500 cc. of yellow fluid. Between May 11 and July 5, seven abdominal paracenteses were performed, yielding a total of 43 liters of fluid. The fluid was always yellow and contained fat globules. It was examined several times for tumor cells, but none were found.

Because the ascitic fluid seemed to be forming more rapidly, laparotomy was again performed on July 13. At that time a large cavity measuring 25 by 30 by 15 cm. was found anterior to the abdominal viscera. This cavity was lined with a thick, reddish-purple exudate and walled off the viscera so completely that neither the bowel nor the various other organs were seen. The cavity was packed with six five-inch wide, six-yard iodoform packs; and the abdominal wound was closed with through and through silk sutures. Nine days postoperatively the first pack was removed, and the remaining five packs were taken out during the following three-week period. The patient has since recovered completely and has been without signs or symptoms for the past 18 months.

### Comment

Because of the marked exudative reaction produced by ruptured dermoid cyst, abdominal carcinomatosis and tuberculous peritonitis must be considered in the differential diagnosis. This reaction of the peritoneum to the contents of the dermoid is chemical in nature[2] and is probably produced by neutral fats, fatty acids and calcium soaps contained within the dermoid. Microscopically, the lesions are granulamatous in nature, containing lymphocytes,[1] plasma cells, and foreign body giant cells.

Since the dense adhesions produced by this catastrophe predispose to mechanical bowel obstruction, this complication should be anticipated whenever rupture of a dermoid cyst occurs.

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## CHICAGO MEDICAL SOCIETY PLAN FOR TRANSPORTATION TO SAN FRANCISCO A.M.A. CONVENTION AND HAWAIIAN TOUR

The Transportation Committee of the Chicago Medical Society announces a special all air transportation plan to the A. M. A. Convention at San Francisco and a tour of the Hawaiian Islands following.

Take off from Chicago is scheduled for noon on Sunday, June 20, with arrival in San Francisco the same day. Take off for Hawaii will be at midnight on June 25 from San Francisco. The return flight from Honolulu—following a tour of the Islands by air and limousine—is scheduled for midnight, July 4. Return to Chicago will be on July 5.

A few reservations are still available. Those interested may contact Elmer V. McCarthy, M.D., Transportation Chairman, Chicago Medical Society, 86 East Randolph Street, Chicago 1, Illinois.

# THE MEDICAL FORUM

## RURAL ENROLLMENT IN BLUE SHIELD TO BE UNDERTAKEN

Members of the Commission on Prepaid Plans spent a busy week-end in Madison late in March. Snapped in meeting were, left to right, Drs. C. G. Reznichek, Madison; John T. Sprague, Madison; Robert Krohn, Black River Falls.

### Three More Counties to Vaccinate Against Polio

Madison, April 3.—Three more counties are to take part in the national program to test the newly developed vaccine for polio, according to Dr. C. N. Neupert, state health officer.

These are Eau Claire, Rock and La Crosse Counties. They bring to eight the number of counties in Wisconsin in which the vaccine will be tried, the others, previously announced, being Milwaukee, Dane, Fond du Lac, Kenosha and Wood Counties.

In all eight of the counties, all second graders will, with the permission of their parents, receive vaccinations, and their records will be checked against those of first and third graders for polio incidence.

The vaccine will be administered by members of the county medical society in each of the designated counties. Each child will receive two shots a week apart, and a booster about a month later. The program will begin about May 1.

Doctors in charge of the programs for their respective counties are Charles K. Kincaid, Dane; Harold J. Kief, Fond du Lac; Robert G. Welsch, Kenosha; Joseph E. Vaccaro, Milwaukee; James R. Heersma, Wood; G. J. Egan, La Crosse, H. D. Nester, Eau Claire; and J. R. Schroder, Janesville and F. K. Johnson, Beloit, Rock.

### *HERE'S AN IDEAL BOOKLET FOR A RECEPTION ROOM*

"Medical Research May Save Your Life."

That is not only a true statement, but also the name of a new Public Affairs Pamphlet, which is recommended reading for doctors, their patients and their friends.

Written by Gilbert Cant, medical editor of *Time* magazine, it tells how the research conquests of the past decade have added years to the average life.

It tells how the infectious diseases of childhood have been largely conquored by research, and uses the fight against polio as an example of how research, properly supported, can achieve a major breakthrough against a dread disease.

These pamphlets cost 25¢ each, and may be obtained by writing to the State Medical Society, Box 1109, Madison.

### Commission to Initiate Experiment in Polk, Barron Counties

Madison, March 22.—An experimental sales program for the enrollment of rural people in Blue Shield health care protection has been announced by the State Medical Society.

Plans for the program were outlined by the society's Commission on Prepaid Plans at a late March meeting.

The program will be conducted in the Polk–Barron county area of northwestern Wisconsin, according to Dr. E. M. Dessloch, Prairie du Chien, chairman of the commission.

Dr. Dessloch said the new program was being undertaken because "the medical profession belives that its objective is not served fully if sparsely settled areas are neglected in the sales actvities of Blue Shield and people left to shift for themselves without the opportunity to purchase adequate health insurance."

#### To Hire Rural Salesman

Most insurance plans have bypassed areas where there are few people employed in groups and where the cost of enrolling the self-employed person is thought to be high. Blue Shield will employ a man exclusively for rural selling efforts by July 1. He will offer Blue Shield on a non-group basis to farmers and others of the self-employed. The Blue Shield policy will offer benefits for surgical, medical, x-ray, anesthesia and maternity services.

At the commission meeting, Dr. Robert Krohn, Black River Falls, was re-designated vice-chairman of the commission; Dr. N. A. Hill, Madison, treasurer and Dr. John T. Sprague, Madison, assistant treasurer. C. H. Crownhart, Madison, continues as secretary of the commission.

Dr. H. Kent Tenney, Madison, president of the society, was

*(Continued on page 252)*

# VETERANS MEDICAL SERVICE HANDLES HOME TOWN CARE

**What does the State Medical Society do for its members? This is the sixth in a series of articles which explain the services of the society to the physicians who belong to it.**

Out of the vast government setup for giving medical care to veterans has come the Wisconsin Veterans Medical Service Agency.

Since 1947, the State Medical Society headquarters has housed this agency which pays "home town" medical care bills for veterans with service-connected disabilities.

### Serves as Liaison

It is the agency's function to serve as liaison between the Veterans Administration and the physician—checking authority to treat against treatment given, and paying the physician for the work he does.

A physician becomes a member of the agency by indicating to the State Medical Society his desire to participate in the program. When he indicates this, he agrees to abide by the fee schedule which has been settled upon between the Veterans Administration and the State Medical Society.

Under the plan, when a veteran needs treatment for his service-connected disability, he goes to his home-town doctor and the doctor is required to send to the Veterans Medical Service Agency within 15 days, a request for authority to treat the patient. This request, which is known as Form 100, is forwarded to the VA for action.

### VA Checks Records

The VA checks the veteran's record, and if it is determined that his disability is service-connected, and time regulations are complied with, authorization to treat is sent to the agency.

From this authorization the agency sets up another Form, known as Form 200, which goes to the doctor to be filled out. This form is an authorization for the physician to treat the patient and bill for his services in accordance with the fee schedule. On this form is shown exactly what treatment the VA has authorized, and the period of treatment.

VETERANS MEDICAL SERVICE AGENCY at work. The girl at left is checking the panel of participating physicians.

Except in certain special cases, authority to treat is for one month only. At the end of this period, the doctor sends back to the agency the Form 200 on which he has itemized the services he has rendered, with dates and fees. He must give a complete report of treatment rendered, with physical findings.

### Agency Mails Checks

The agency processes and sends the forms to the Veterans Administration. The Veterans Administration then sends a check to the agency — each check covering a number of bills. Individual checks are written by the agency and mailed to the physicians.

If the treatment is to be continued longer than the month, its continuation must always be requested in advance.

Occasionally a veteran appeals directly to the regional office of the VA for treatment, and in such cases, an authority to treat, already passed upon by that office, is received by the agency. The Form 200 is then forwarded to the doctor.

If, during a month, additional treatment beyond what was authorized is considered necessary by the physician, he may charge for this on his Form 200, and if he explains well enough to show justification for the treatment, and it is medically approved by the VA, it will be paid. This is a recent relaxation of a formerly stringent rule.

Veterans of the Spanish American War also receive treatment under this program. They get care for any ailment on an out-patient basis, with no need to prove service connection. The same thing is true of veterans who are receiving vocational rehabilitation under Public Law 16. They may receive treatment at VA expense for any condition which interrupts their vocational training.

### Korean Vets Included

Korean veterans whose disabilities are presumed to have resulted from their service on or after June 27, 1950, are also provided treatment under the home town care program while the VA determines whether their disabilities are service-connected.

Two girls in the State Medical Society's office work full-time in this agency. Another works half-time, and there is a director of the agency who also devotes about half his time to this work.

Approximately 1,000 authorities are received from the VA each month, and over 800 claims are paid. The agency has paid over $1,500,000 to participating doctors since its inception in 1947.

# 4-H CLUBS RECEIVE "TODAY'S HEALTH" SUBSCRIPTIONS

Madison, April 14.—A total of thirty-nine 4–H clubs have qualified to receive a year-long subscription to "Today's Health" through the courtesy of the State Medical Society.

The gift subscription to 4–H clubs has been developed by the Council on Medical Service, under the leadership of Dr. D. E. Dorchester, Sturgeon Bay, and Dr. R. L. MacCornack, Whitehall, as an incentive to 4–H club leaders and members to perform more excellent work in the field of health and safety.

### One Per Community

**Only one 4–H club in each county is eligible to receive the subscription to "Today's Health" The club leader will receive the copy each month and will circulate it among club members for study and project work.**

The clubs and leaders which are receiving "Today's Health" during 1954 are: Plainfield Happy Hustlers, Mrs. Russell Smoker, Plainfield; Pearce Peppers 4–H Club, Robert Hagen, Ashland; Columbus Busy Bees, Mrs. Edward Spielman Barron; Kelly Boosters, Thomas Hecimovich, Ashland; Greenleaf Club, Mrs. George Haen, Greenleaf;

Lucky Griffin, Arnold Gehrke, Alma; Pleasant Valley, Mrs. Henry Muenah, Bloomer; Chili Club, Mrs. E. C. Haslow, Chili; Watertown Badgers, Mrs. Arthur Hoffer, Watertown; Blanchard, Mrs. Leonard Buckley, Menomonie;

### Other Clubs Listed

**Lucky Lincoln, Mrs. Frank Westphal, Fall Creek; South Byron Club, Mrs. Clinton Ehrhardt, South Byron; Sunrisers, Mrs. Clarence McClelland, Berlin; Jolly Juveniles, Mrs. Gordon Williams, Dodgeville; Gurney 4–H Club, Mrs. Dave Galarno, Gurney;**

Oakland Girls, Mrs. Wilfred Gottschalk, Fort Atkinson; Salem Pioneers, Jasper McCormick, Salem; Chipmunk Coulee, Kenneth Harold, Stoddard; Jennings Hustlers, Mrs. William Shager, Woodford; Mayflower, Mrs. George Miller, Antigo;

Reedsville Tip Top, Mrs. Emil Wenzlaff, Reedsville; Working Beavers, Mrs. Delbert Henquinet, Peshtigo; Reels Valley, Mrs. Henry Bruder, Tomah; Christy Brook, Mrs. Ray Metz, Gillett; Rainbow, Mrs. John Coenen, Appleton;

**Waubeka Club, Mrs. Joseph Hames, Waubeka; Helpful Workers, Mrs. Ed Prine, Ellsworth; Arnott Stars, Mrs. L. P. O'Keefe, Stevens Point; Lakeside Loyalties, Mrs. John Froeming, Butternut; Gotham Go-Getters, Mrs. Archie Shadewald;**

Happy Go-Lucky, Mrs. Carl Cudo, Weyerhauser; Plum Valley, Mrs. Emil Backeberg, Wonewoc; Bowler Club, Mrs. Arnold Doede Bowler; Wide-Awakes, Mrs. Ben Dekker, Hingham; Liberty Pole Boosters, Mrs. Roy Robson, Viroqua;

Deerskin, Verna Stenback, Phelps; Hillside Hustlers, Mrs. Fred Kuenzi, Colgate; Summit Valley, Mrs. Ernest Kraft, Oconomowoc; Howlett Hustlers, Mrs. Viola Luebke, Oshkosh.

## Hospital Staff Sponsors "Do You Have a Family Doctor?" Advertisements

Dover, Ohio, March 18.—A series of advertisements asking pointedly "Do you have a family doctor?" is currently appearing in the Dover newspaper.

Sponsored by the staff of the Dover–New Philadelphia Union Hospital, the ad has been running weekly for several months.

"The family doctor is ordinarily a general practitioner, a doctor of medicine, who has received his M. D. degree from a recognized school of medicine and who has had at least one year of internship in an approved hospital," the ad states. "Once having selected a doctor, go to his office and get acquainted with him so that he knows you when you need to phone him about some illness or emergency which might arise in your family. Your first thought when an emergency or illness arises should be your *family doctor*."

Although many county medical societies sponsor night and emergency call systems, ads such as this can lighten the number of calls from families who have not selected a doctor before illness occurs.

## New Hospital Grants Approved for Wisconsin

Madison, April 2.—Two new grants for hospital construction in Wisconsin under the Hill–Burton Act have been approved by the Hospital Division of the State Board of Health.

An addition to house 74 beds is to be added to Bellin Memorial Hospital, Green Bay, at a cost of $1,512,595.

St. Croix Falls will have a new 20-bed facility which will cost $300,000.

The Federal share of the Green Bay addition will be $325,000; of the St. Croix Falls Hospital, $135,000.


**TIME IS YOUR ONLY REAL ASSET**

You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

*Disability Specialists since 1892.*

## DR. NEWCOMB'S TELEVISION APPEARANCE RETIRES DEBT ON LAKELAND HOSPITAL

Woodruff, Wis., March 24.—Dr. Kate Pelham Newcomb, Woodruff physician and chief of staff of the new Lakeland Memorial Hospital, appeared on the television show "This is Your Life," over a nationwide hook-up March 17.

Dr. Newcomb went to California under the impression she was to represent the State Medical Society at a medical meeting in Los Angeles. The Woodruff residents who appeared on the show with her were flown west the day after she left.

**The show presented the story of her life, and on it, Master of Ceremonies Ralph Edwards appealed for funds to help retire the debt on the hospital, which was built by the community so that Dr. Newcomb would no longer have to drive twenty miles to Rhinelander or Tomahawk to make hospital calls.**

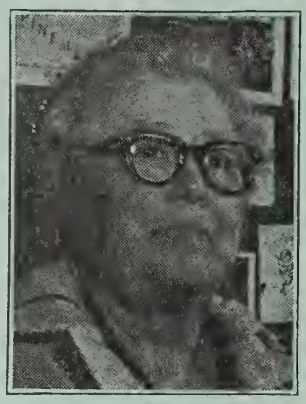
A unique feature of the hospital fund drive was the million penny campaign started by a high school geometry class' idea that it would like to see a million of something.

### Debt Was $32,000

Well over a million pennies came in from all over the nation, but the hospital still had a debt of $32,000 when Dr. Kate went to Hollywood. As a result of her appearance and Edwards' appeal, the debt is now retired. By March 25, 298 pouches of mail had arrived in Woodruff. More than the $32,000 had been counted, and the total of contributions was estimated at over $75,000.

**AMA employes, many of whom were deeply touched by Dr. Kate's unselfish work, contributed more than 3,000 pennies during the first two hours of the morning following the telecast.**

Dr. Newcomb graduated from the Medical School of the University of Buffalo in 1917 and interned at the Woman's Hospital, Detroit. She moved to northern Wisconsin from Detroit when her husband fell ill. There she nursed him back to health, and she was a busy housewife and mother for a number of years. In 1931, she responded to an emergency call, and found herself back in the practice she has continued ever since.



DR. KATE PELHAM NEWCOMB
Milwaukee Journal Photo

She returned to Woodruff after the television show in a new car which she received on the program. She arrived in time to attend the formal opening of the hospital, but missed part of the ceremony because she was called to Tomahawk to deliver a baby.

## Plaques Which Plug Mediation Committee Displayed by Doctors

Lexington, Ky., April 4.—Physicians who belong to the Fayette County, Ky., Medical Society display in their offices framed, printed plaques which call the attention of patients to the society's mediation committee.

The plaques read: "Your doctor is a member of the Fayette County Medical Society. If you, as his patient, feel that his treatment of you has been in any way unjust or his purpose dishonest or unethical, you should report it to his society. Write your complaint in full detail; sign and address to Professional Relations Committee, Fayette County Medical Society."

Doctors who display them feel that they encourage a more forthright relationship between doctor and patient, and help to establish in the patient's mind that the medical profession is alert to see that the present high level of medical care is maintained.

## *MALPRACTICE INSURANCE IS COSTLY*

**(To be sung to the tune of "Tit-Willow")**

If you think consultations are "extra expense,"
Malpractice insurance is costly.
If you give verbal orders to those who are dense,
Malpractice insurance is costly.
If you leave for the country without substitute,
Or you give the impression you don't "give a hoot,"
I'll tell you now, doctor, you're in for a suit.
Malpractice insurance is costly.

If you fail to x-ray all fractures of bones,
Malpractice insurance is costly.
If you choose to do pelvics without chaperones,
Malpractice insurance is costly.
If you criticize colleagues for work they have done,
If you tell all your patients you're the only one,
I'll tell you now, doctor, attorneys will run.
Malpractice insurance is costly.

If you shoot off your mouth when your patients confide,
Malpractice insurance is costly.
If you dare to make house calls when "pickled or pied,"
Malpractice insurance is costly.
If you cut open patients with greatest of ease,
And your only intent is collection of fees,
I'll tell you now, doctor, start shaking your knees.
Malpractice insurance is costly.

—Milton J. Chatton, M. D., Santa Clara County Hospital.
Courtesy, Bulletin of the Santa Clara (Cal.) County Medical Society.

## *MD'S RECEPTIONIST IS KEY PERSON IN HIS PUBLIC RELATIONS PROGRAM*

If you employ an assistant—a combination nurse, secretary and receptionist — who presides over the waiting-room, assists you with patients and does your office work, she is a key person in determining what people think of you and your office. Into her hands you entrust the good will of your patients.

Some physicians succeed with the help of good assistants—others in spite of office personnel. How do your assistants treat your patients? Make it a point to evaluate your assistant in her dealings with patients. Thoughtlessness or carelessness can spell doom for your "personal" public relations.

**A neat, attractive assistant is "good medicine" for any patient. As your good-will ambassador she should have a nice personality, combining friendliness, courtesy, graciousness and sympathy. A girl who dislikes or becomes impatient with people should not work in a doctor's office.**

A sad-faced gal with a mournful mien, a bored miss with a perpetual sneer, or a dragon who strikes terror into hearts of patients are no assets to a physician. His assistant should be cheerful, tactful and efficient, prepared to meet any emergency with cool-headed composure.

Are you wondering how to find such a paragon of an assistant? One doctor suggests using the systematic techniques developed by personnel experts—job evaluation, careful screening and testing of applicants—rather than the hit-or-miss approach.

You can purchase ready-made kits which provide interview guides and necessary forms from The Personnel Institute or The Psychological Corporation, or you can design materials to fit your own needs. A girl who is still in the running after you follow this procedure is likely to be a pretty good bet:

1. **Decide exactly what tasks the job entails.**
2. **Decide what sort of girl you want in terms of age, marital status and education.**
3. **Enlist the aid of your staff, colleagues, friends, schools, employment agencies; advertise in newspapers or professional journals for applicants.**
4. **In interviews, rate girls on personality, voice, poise, intelligence, self-confidence, education, ambition, etc.**
5. **Have applicants fill out a personal history form.**
6. **Hold final interviews with the best applicants.**
7. **Get a third-person check by phone from a past employer.**

An efficient assistant can save you time and money, but she must be thoroughly trained. Outline her duties clearly and specifically—and don't expect her to learn everything the first day.

Impress upon her the importance of attention to detail and warn her that mistakes in a doctor's office can be tragic. Stress the importance of maintaining patients' office confidences. Work out in advance agreements on just what procedures are to be followed in specific situations.

Many a doctor's assistant is reduced to tears when her boss flails her verbally for a slip-up in front of a patient. Save your thunder for her ears only—and encourage her to come to you when she has grievances or suggestions.

**Good assistants deserve good wages—it is foolish to hire a girl merely because she will work for less money. Most girls don't mind working overtime now and then, but show your appreciation for their loyalty in tangible ways —with a little extra time off now and then or with a substantial bonus.**

A loyal, personable and well-trained assistant can be your biggest public relations asset.

(*Note:* This article was reprinted from the new AMA Public Relations Manual.)

## Total Cost of Medical Diploma Averages $9,200 Today, Survey Discloses

Chicago, March 25.—Medical college training in the United States costs approximately $9,200 today.

According to a study made by the Association of American Medical Colleges, based on questionnaires sent to students at 26 medical schools, this was the average figure. It did not cover the cost of premedical training, internship and residency training, or the cost of setting up in practice.

**On the basis of this figure, medical education in Wisconsin is below the average cost. It is estimated that a student who lives in Wisconsin can get through the University of Wisconsin Medical School for about $5,232, while a non-resident student with proportionally higher tuition can get through for $6,512.**

### Marquette Slightly Higher

The cost of training at Marquette University School of Medicine is about $7,272. These estimates are made on costs of tuition, books, travel within the city, board and room, laundry and cleaning, and recreation.

About one third of the students who replied to the questionnaire expect to be in debt when they graduate from medical school, to the tune of approximately $3,500.

About half are single and living away from home. Most of the money for the single student comes from his parents, while the married student is usually supported by the earnings of his wife.

Income of the students questioned varied widely, with $2,450 being the average. Vacation earnings contribute only a small amount—an average of $550.

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

# DISTRIBUTION OF PHYSICIANS IN U. S. EXCELLENT, DICKINSON SURVEY SHOWS

## Report to Be Ready in Booklet Form Early Next Month

Chicago, March 28.—Distribution of physicians in the United States in relation to the patients they serve is extraordinarily good.

This fact is brought out in a seven-year study made by Frank G. Dickinson, Ph.D., Chicago, director of the American Medical Association's Bureau of Medical Economic Research.

**For purposes of the study, Dr. Dickinson divided the country into 757 medical service areas, using the trade area principle quite irrespective of county and state boundary lines.**

### Number Varies

The number of persons in each area per active practitioner varied from 5,100 in the area around Monticello, Utah, to 380 in the Rochester, Minn., area.

Only 75 out of the 757 areas had more than 2,000 per active physician. These were among the most sparsely populated portions of the nation, and the addition or redistribution of only 361 physicians into these areas would have alleviated this condition.

**Dr. Dickinson pointed out that while one-sixth of the land area of the United States was outside a 25-mile radius of the closest town with an active physician only one-sixth of one per cent of the population lived in this area—this figure based on the 1950 census.**

### Most Have Practitioners

According to the report, there is not a town with more than 5,000 population which does not have at least one physician in private practice. Of towns with a population between 2,500 and 5,000, 90 per cent have at least one doctor as do 88.3 per cent of towns with 1,000 to 2,500 population.

Dr. Dickinson's report emphasized that, with today's good road and fast transportation, a patient 25 miles from a doctor is nearer in point of time than he would have been at a 10-mile distance a few years ago.

**It is Dr. Dickinson's opinion that, from the standpoint of public welfare, the greatest current shortages of highly trained personnel occur in the fields of physics, chemistry and teaching.**

The survey touched on the subject of physicians in the armed forces, observing that about 40 per cent of the country's physicians were in uniform, leaving 60 per cent to care for the 91 per cent of the population which remains civilian.

The study, first released at the recent AMA Conference on Postgraduate Education and Licensure, will be available in booklet form in May. Copies of it may then be obtained by writing to the State Medical Society, Box 1109, Madison.

## *PAMPHLETS FOR YOUR PATIENTS*

**Excellent public relations literature is available without cost from your State Medical Society office. Order a quantity now. They are available only in shipments of 50 or less. Send your order to: Public Information, State Medical Society of Wisconsin, 704 East Gorham Street, Madison**

* * *

**"What About This Doctor Shortage?" A Reader's Digest article that answers the charge of doctor shortages.**

**"Factbook on Medical Education"—Facts and figures on U.S. medical school enrollments, financial support, and faculty indicating that more and better trained physicians are being graduated.**

**"Your Money's Worth in Health"—A colorful booklet reports the negligible increase in medical fees compared to the general cost of living and shows that the medical dollar today buys more and better treatment than fifteen years ago.**

**"The AMAzing Story"—Many ways in which the average American family is served by the AMA and its physician members.**

**"Science vs. Chiropractic"—A public affairs pamphlet which exposes chiropractic as a cult having little validity in proven science.**

## Suggestion Offered For Problem of Crank Letters to the Editor

New York, March 20.—Cranks and individuals representing pressure groups have a fondness for using Letters to the Editor columns of newspapers for airing all sorts of fancied grievances against the medical profession.

Since they are often not averse to dealing with personalities rather than generalities, their accusations may be damaging both to the individual doctor and to medicine as a whole.

### Simple Solution

A simple, effective way of handling complaints about physicians received by newspapers has been suggested by a county medical society in New York State. It suggests that medical society officers inform local editors of their willingness to investigate complaints *before* they are published as letters to the Editor.

The society advises encouraging the assignment of a reporter as liaison between physicians and the newspaper. Doctors then work with the reporter in interviewing complainants to determine whether the facts justify the charges. This method of joint investigation, according to the New York newsletter, reveals that "the great majority of cases are without foundation."

## RURAL ENROLLMENT . . .

*(Continued from page 247)*

named to the executive committee of the commission, and appointed to its committee on physician and public relations were Drs. A. J. McCarey, Green Bay, and W. T. Casper, Milwaukee.

Target date for the new catastrophic policy which is to be written by Blue Shield is July 1. It is to be written with a deductible feature. It will cover all of the physician's services and 80 per cent of ancillary services and supplies, up to $5,000 per person or $15,000 per family. It will be sold only on a group basis at first, and only to large groups.

At this meeting, the commission also approved adding maternity benefits to the WPS non-group contract. The usual nine-month waiting period will apply.

# WISCONSINITES GO TO RURAL HEALTH MEET IN DALLAS

## Next Conference to Be Held in Milwaukee In February, 1955

Madison, March 8.—Nutrition, voluntary health insurance, and the value of group action in solving health problems were the subjects emphasized at the tenth annual Rural Health Conference in Dallas early in March.

Especially stressed was the need for physician participation in community affairs.

**Attending from Wisconsin were Dr. and Mrs. John A. Van Susteren, Sparta; Dr. Robert Parkin, Madison, dean of postgraduate medical education at the University of Wisconsin; Dr. Allan Flek, Madison, of the State Board of Health; Miss Edith Bangham, Madison, of the University's Home Economics Extension and president of the Wisconsin Public Health Council; and Jerry Seaman, Milwaukee, who is employed by radio's National Farm and Home Hour.**

### Dr. MacCornack Absent

Dr. R. L. MacCornack, Whitehall, the member of the Council on Medical Service whose special interest is rural health, was unable to attend at the last minute. Miss Bangham was singled out for special attention because she has not missed one of the ten Rural Health Conferences.

The nutrition talks were aimed at the overweight problem and the need for better diet among rural people. It was reported, however, that food habits are improving, with people eating more fruits, vegetables and meats, and less of the starchy foods.

The health insurance discussions pointed up the fact that health insurance should be purchased on the carefully considered merits of the contract.

**An interesting experiment in nurse recruitment among high school girls was reported by the superintendent of the Akron, Colorado, hospital. Sponsored by the high school auxiliary, the club of JUGs (Just Us Girls) was recruited from among eighth grade and high school girls. They received training at the hospital and also from the public health nurse in preparation for nurses training later on. A color film of JUGs in action, made by Blue Shield of Colorado, was displayed.**

The closing address was delivered by Dr. Edward J. McCormick, Toledo, president of the AMA.

Wisconsin will be host to the Rural Health Conference next year. The event is scheduled for February 24, 25 and 26 in Milwaukee.

DR. W. B. HILDEBRAND

## HILDEBRAND HEADS AMERICAN ACADEMY FOR COMING YEAR

Cleveland, March 23.—Dr. W. B. Hildebrand, Menasha, was installed as president of the American Academy of General Practice at the academy's annual meeting in Cleveland March 22–25.

Dr. Hildebrand, one of the founders of the Wisconsin academy, is an active member of the Winnebago County Medical Society and the State Medical Society. He has been president of the board of directors of the American academy.

In his inaugural address, Dr. Hildebrand answered charges which have been leveled by the American College of Surgeons at general practitioners to the effect that they are unskilled as surgeons and perform unnecessary surgery, though he did not refer to the college by name.

**"Far too much name calling has already taken place," Dr. Hildebrand said. "The only way the academy and each individual in it can and should retaliate is to so elevate the standards of general practice that no one in or out of the medical profession dare raise his voice against it in criticism."**

He said that "frenzied outbursts" do not help in achieving "dignified, cordial relationship between all other groups in organized medicine and the academy, and providing better medical care."

Because he was shortly to assume this office, Dr. Hildebrand was called to Washington in January for a briefing by Mrs. Oveta Culp Hobby on the health program newly advocated by the Eisenhower administration. He characterized it as a "toned-down New Deal program," but thought well of the proposal to establish more facilities for care of the aged.

## Some WMA Member Will Get All-Expense Trip To Assembly in Rome

New York, March 22.—One member of the United States Committee of the World Medical Association will be given an all-expense trip to the 8th General Assembly of the association, which will be held in Rome September 25 to October 3 this year.

Physicians who would be interested in making this trip should write to the World Medical Association, United States Committee, Inc., 345 East 46 Street, New York 17, and apply for committee membership.

The winner of the trip will be determined by a drawing at the AMA convention in San Francisco in June. Only committee members are eligible, and their memberships must be received in New York not later than June 10, or delivered personally to the Civic Auditorium in San Francisco between 9 a. m. June 21 and noon June 24.

This trip is to include round-trip first-class fare by air from New York to Rome, and hotel accommodations in Rome from September 25 to October 3.

Dr. Louis H. Bauer, Rockville Center, N. Y., former AMA president, is secretary-treasurer of the United States Committee.

## "Cupping" Equipment Given to Section on Medical History

Madison, April 10.—The State Medical Society's Section on Medical History has received from Dr. Stephen E. Gavin, Fond du Lac, a "doctor bag" filled with equipment used for "cupping."

This bag contains a suction pump which was operated by a small hand crank. The set includes various cups, tubes and needles which could be attached to the pump.

The bag was the property of the late Dr. Karl L. De Sombre who was born in Fond du Lac in 1861. Dr. De Sombre was graduated from the medical school of the University of the City of New York in 1889. His registration cards for the various courses he took have also been turned over to the society, and are pictured on this page.

### Card for Each Course

According to these cards, his medical school course included anatomy, histology, pathology, physiology, chemistry, surgery, clinical instruction, obstetrics, diseases of women and children, and operative surgery and bandaging. The cards range in size from 6 x 4 inches to a modest 4½ x 2½ inches. Some of the cards for spring term courses are airily decorated with flowers.

Dr. De Sombre served with the armed forces during the Spanish-American war and returned to Fond du Lac to go into medical practice. From there he moved to Princeton and then to Medford. After his retirement, he returned to Fond du Lac where he lived until the time of his death in 1937.

**THE OLD MEDICAL KIT pictured here was used for the obsolete practice of "cupping." The bag, of black leather, is lined with purple plush and contains a number of needles, tubes and cups which were attached to the suction pump pictured outside of the bag. Also shown is the set of medical school registration cards of a medical graduate of 1889. All were the property of the late Dr. Karl L. De Sombre who practiced in Fond du Lac, Princeton and Medford.**

## Crosby Succeeds Bugbee As AHA Executive Head

Chicago, March 24.—Dr. Edwin L. Crosby, Chicago, has been appointed to the post of executive director of the American Hospital Association, to succeed George Bugbee.

Dr. Crosby was formerly director of the Joint Commission on Accreditation of Hospitals. Bugbee has become president of the Health Information Foundation, New York City.

## Switzerland Has Most American Med Students In Foreign Countries

Chicago, April 6.—Switzerland had the largest enrollment of American medical students studying abroad last year, according to the AMA Council on Medical Education and Hospitals.

Out of 1,734 such students, 471 were in Switzerland, 393 in Spain, 190 in Italy and 180 in Mexico.

Puerto Ricans, who gravitate toward Spanish speaking countries, accounted for 383 of those in Spain and 126 in Mexico.

Other foreign countries where more than 50 American students were enrolled include Germany, France, Belgium, the Dominican Republic, Austria and the Netherlands.

The University of Geneva had the largest number of any one school with 180 American students listed.

## *PUBLIC RELATIONS TIP FOR APRIL*

Madison, April 12.—Having "trouble" with your local newspaper?

Here's an idea that may go over with the newspaper boys and which can do a great deal to create better understanding of the medical profession:

A county medical society can well afford to issue a medical directory to members of the press, radio and television stations which lists names and phone numbers of the county medical society offices or of county society officials who may be called if a medical or health problem occurs which needs immediate clarification. Too often the newspapers and other media do not know whom to call if they want a statement from the Medical Society or want to clarify some information about new drugs or other medical stories.

# Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

## Shock Following Severe Trauma

Prevention of complications during surgical procedures is the aim of every surgeon and anesthesiologist. This is usually accomplished by adequate preoperative evaluation and preparation plus definitive therapy during administration of anesthetic agents and the operation itself.

Emergency patients, on the other hand, may inadvertently be deprived of such minute evaluation. Frequently the individual is rushed to the x-ray department for quick screening or to the fracture room without much attention being given to the general physical status. Severe shock develops in many of these individuals when they are subjected to anesthetization and surgical manipulation.

It is an accepted fact that patients who have received even minor injuries suffer from some degree of "shock" even though the condition is not apparent by the usually accepted criteria of skin pallor; rapid, weak pulse; reduced venous pressure; low blood pressure; shallow respiration; and restlessness. Attention should be directed first toward early stabilization and preparation of the patient to withstand the necessary diagnostic and operative procedures. The time spent for administration of supportive measures is worth while and may prevent the development of more serious complications which cannot be ameliorated. The sudden development of shock may only be the forerunner of irreversible cardiorespiratory difficulties and subsequent cardiac arrest.

The Wisconsin Anesthesia Study Commission presents a case demonstrating the development of severe delayed decompensation and shock following trauma and anesthetization.

Case 53—A 72-year-old white male was admitted to the emergency room following involvement in an automobile collision. He was conscious and appeared well oriented. He was transferred to the x-ray department, where diagnostic films revealed a severe fracture dislocation of the left hip, fractured left patella, and fractures of the bones of the right hand.

After subcutaneous administration of 8 mg. of morphine sulfate and 0.4 mg. of scopolamine, he was anesthetized with 450 mg. of 5 per cent sodium pentothal given intravenously. Maintenance of anesthesia was accomplished with trichlorethylene and nitrous oxide, by semiclosed technic. Twenty milligrams of succinylcholine was given intravenously for muscular relaxation, and closed reduction of the dislocated hip was attempted without success. No blood pressure readings were taken, and no supportive fluids were given during the procedure. The pulse rate fluctuated between 76 beats per minute and 112 beats per minute.

The patient was returned to his room semiconscious and responding to stimuli. Within a few minutes, symptoms of severe shock suddenly developed. He became very pale, his skin was cold and moist, and he had a Cheyne–Stokes type of respiration. Systolic blood pressure was 60 mm. of mercury. Five hundred cubic centimeters whole blood was administered intravenously under pressure. The blood pressure increased to 100/65. Respirations continued to be of poor quality and oxygen at a flow of 6 liters per minute was administered by oropharyngeal catheter. Another 500 cc. whole blood was given, and the blood pressure stabilized at 100/65. The quality of respirations improved. Twelve days later an open reconstruction of the left hip was performed without any difficulty, and recovery was without incident.

Traumatic shock may be a very insidious cause of circulatory collapse. Sudden decompensation is most apt to occur in patients with penetrating wounds of the abdomen, chest, or skull; involvement of a major blood vessel; or major fractures of the long bones.[1]

The latest concept of this syndrome is one of profound alteration in normal metabolism.[2] It has been shown that trauma, whatever its nature, results in a negative

nitrogen balance through the liberation of ACTH by the pituitary gland and resultant gluconeogenesis. This includes plasma proteins which are rapidly metabolized to urea, with a reduction in a blood volume adequate for normal cellular metabolism.

The sustaining mechanism in shock, however, is impaired liver function as a result of decreased oxygen supply. A circulating vasodepressor material is produced by ischemic muscle and liver tissue. The substance, in turn, paralyzes the precapillary sphincters so that they no longer respond to nerve impulses or epinephrine. A wide capillary bed leads to trapping of red cells. The net result is a fall in venous pressure, a decreased cardiac output, and a drop in blood pressure.

The prevention of irreversible shock following injury centers around the correction of those factors which accompany the initial shock picture—altered circulatory volume, disturbed cardiorespiratory mechanism, dehydration, pain, and exposure.[1] Serial hematocrit readings may indicate the degree of hemodilution or hemoconcentration and serve as a guide for the administration of whole blood and plasma expanders. It is important that opiates or other pain relief medications be administered in small doses intravenously. The impaired peripheral circulation fails to absorb drugs from the subcutaneous or intramuscular sites; and large doses, often repeated because of little or no apparent effect, may cause severe respiratory depression later when adequate circulatory dynamics have been restored.

Every attempt should be made to put the patient in the best possible condition before subjection to anesthetization and surgical procedures. To further the adaptation of the patient to stress and strain of necessary surgical interference, the anesthesiologist can best serve by allowing the patient as full use as possible of his normal physiologic protective mechanisms through the diligent use of anesthetic agents and constant attention to their administration and effect upon the patient.[3] Close observation of pulse rate and blood pressure is necessary, as slight changes in these signs may be the earliest indications of impending circulatory failure and shock.

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## ANESTHESIA AND ANALGESIA

Physicians attending births can provide valuable information by carefully recording anesthetics and analgesics that were used under Item 29 on the latest birth and fetal-death certificates. This data is being collected and tabulated at the request of the State Medical Society's Division on Maternal and Child Welfare, which is currently undertaking special studies on maternal and fetal-neonatal deaths.

One of the problems encountered has been the reporting of such non-specific items as "General," "Gas," "Routine," "Ob," or just a "√" or "X." Even worse is no entry at all—which could mean the type of anesthetic and analgesic was not indicated or that none was used.

Information gleaned from birth certificates in the past has been valuable to all practicing physicians in Wisconsin. It has broadened knowledge of problems and helped to direct effort toward improved care which has reduced maternal and infant deaths. To be of real value, information collected must be meaningful. We therefore urge all physicians attendant at deliveries to help by entering the *specific* anesthetic and analgesic or "None" if none was used.—ROBERT PURTELL, M. D., *Chairman, Division on Maternal and Child Welfare.*

# Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

## Questions and Answers Suggested by Recent Investigations in Drug Therapy

*How is hexamethonium believed by some observers to relieve congestive heart failure?* Low output heart failure leads to an increase in peripheral resistance as a result of reflex vasoconstriction, thus adding to the work of an already failing heart. In addition, diminished cardiac output mechanically induces a redistribution of total blood volume toward the larger veins; and the failing right heart is subjected to excessive filling pressures, thus producing a further decrease in output. Constriction of smaller postarteriolar vessels may further contribute to the venous engorgement. Thus, a vicious cycle is established. Diminished cardiac output induces increased peripheral resistance and central venous congestion, both of which add further loads to the failing heart.

At Georgetown University, Robert T. Kelley, Edward D. Freis, and Thomas F. Higgins[1] recently gave hexamethonium to 19 patients with congestive heart failure in an attempt to decrease peripheral vascular resistance and central engorgement. The average dose was 30 mg., and the average fall of the mean blood pressure was 35 mm. of mercury. All patients with elevated venous pressure had a significant reduction (mean of 82 mm. water) after treatment. The most striking results were in persons with hypertensive heart disease and aortic valvular disease. Eight out of twelve patients with elevated arm-to-tongue circulation times showed a reduction (average, 42 per cent). The heart rate slowed in 12 of the 19 patients, and vital capacity improved in 5 out of 11 on whom determinations were made. Orthopnea was lessened in two thirds of the patients complaining of it. Cardiac catheterization was done on 4 patients, and in each instance there was a fall in intracardiac or pulmonary artery pressure which paralleled the fall in arterial pressure. Cardiac output, determined in one case (direct Fick method), increased after hexamethonium therapy, with a fall in total peripheral resistance and a decrease in right ventricular pressure.

The authors suggest that by decreasing the total peripheral resistance and diverting blood volume to the peripheral vasculature, hexamethonium may decrease the work demand of the left ventricle and reduce the venous overloading of the right heart.

Might this be construed to mean that bleeding, as practiced by our forefathers, was perhaps not always irrational?

*What three symptoms should be watched for during therapy with Fowler's solution?* In reporting a case of toxipathic hepatitis due to Fowler's solution (a case in which the liver was believed to be permanently damaged despite the apparent beneficial effect of treatment with Dimercaprol [BAL]), H. J. Wade and E. S. Frazer[2] warned that Fowler's solution should not be used without consideration of the risks nor without careful clinical control; and they feel that long-continued administration is usually not justified. Hyperkeratosis, subjective symptoms of peripheral neuritis, and liver enlargement should be watched for in any patient receiving this drug.

It is the consensus that the safe limit of administration of Fowler's solution is three courses in which 1 part of the solution and 2 parts of inert vehicle are used as a "drop" mixture. In a "course," the patient starts with 3 drops three times per day after meals and increases 1 drop per dose per day until 30 drops three times daily are being taken; then the dose is reduced 1 drop per dose per day back to the starting point.

*Why must intravaginal penicillin therapy be used with discretion?* In a recent comparison of the plasma concentrations and urinary recoveries of penicillin administered vaginally and orally, Alan Rubin and William P. Boger at the University of Pennsylvania[3] carried out studies on 10 women with no known genitourinary or gastrointestinal disease. After fasting for eight hours, each woman received 2 tablets of po-

tassium penicillin, each containing 100,000 units and all from the same lot, first orally and later by insertion into the posterior vaginal fornix. All patients remained supine during observation. The superiority of penicillin absorption from the vagina, as revealed in the plasma levels, was confirmed by the amounts recovered from the same patient's urine, collected by catheter at the end of three hours; averages were 31.4 per cent after vaginal and 18.6 per cent after oral administration of the same dose of penicillin. The differences were statistically significant for both plasma level and for urinary recovery of penicillin.

Penicillin is absorbed rapidly from the vagina, and plasma concentrations adequate in therapy of many systemic infections can be produced. Since "local" penicillin therapy in the vagina must be considered systemic as well and may induce sensitivity that will preclude systemic penicillin therapy at some later time, it must be used with discretion.

*In what two neoplastic diseases do patients tolerate largest amounts of triethylene melamine?* This drug has a definite but limited place in the treatment of lymphomas and leukemias. The narrow margin of safety in sensitive persons precludes its use without meticulous attention to the status of the blood and marrow during and after treatment. In a recently reported study of oral therapy with the drug in 67 patients, aged 6 to 81, with acute or chronic myelocytic and lymphocytic leukemia, lymphosarcoma, and Hodgkin's disease, Leo M. Meyer and his associates[4] gave the drug in doses of 1, 2.5, 5, 7.5 and 10 mg. to a total of 5 to 20 mg. per course; it was administered early in the morning, and food was withheld for 3 to 4 hours thereafter. Most courses were more than 3 weeks apart. Total doses varied from 15 to 165 mg. Patients with Hodgkin's disease and lymphosarcoma generally tolerated the largest doses of triethylene melamine, while those with acute leukemia, chronic lymphocytic leukemia, and chronic myelocytic leukemia tolerated the least, in the order given. Complications in treatment included occasional loss of hair and frequent leukopenia and pancytopenia, the latter two phenomena reflecting marrow hypoplasia.—HARRY BECKMAN, M. D.

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## DR. E. L. OPIE TO VISIT WISCONSIN ON APRIL 27

Dr. Eugene L. Opie, pathologist of international fame, will visit the University of Wisconsin Medical School on April 27 and deliver the fourteenth annual Charles Russell Bardeen Memorial Lecture under the sponsorship of Tau Beta of Phi Chi.

Doctor Opie, now of the Rockefeller Institute of Medical Research, was a classmate of Doctor Bardeen in the first class of the Johns Hopkins Medical School. He has done a great deal of his work in the pathology of tuberculosis.

His lecture entitled "Fluid Transfer in the Tissues in the Normal and Pathological States" will be given at 8:00 p.m. in the Service Memorial Institute auditorium at the medical school. Preceding the lecture, the annual banquet in honor of Doctor Bardeen will be held, and all Phi Chi alumni are cordially invited. Please send or wire your reservations to Eugene L. Weston, Chairman, 1954 Bardeen Lectureship, 745 University Avenue, Apartment 1, Madison 5.

# Legal Aspects of the Certification of Death

## As It Looks to Your State Board of Health

DIRECTIONS for completing a death certificate, as well as definite assignment of responsibility for each step, are found in the state statutes. At all times the wishes and directions of the next of kin of a deceased person govern the postmortem examination (autopsy) and the disposition of a dead body. The "next of kin" is defined as father, mother, husband, wife, child, guardian, etc. (See sections 155.02, 156.14, 366.19, Statutes).

According to the provisions of section 69.45 (2), the funeral director or person acting as such shall obtain the personal and statistical particulars required from the person best qualified to supply them, over the signature and address of the informant, on the death certificate. He shall then present the certificate to the attending physician or other person authorized by law to fill out the medical certificate of the cause of death and other particulars necessary to complete the record, as specified in sections 69.35 and 69.41.

Over 99 per cent of all deaths occurring in Wisconsin are from natural causes and within the attending physician's personal knowledge, and he is authorized and directed to fill in the medical information over his personal signature.

It is all-important to the funeral director, who must meet the date for the funeral set by the next of kin, that the attending physician be prompt in returning the completed death certificate to him. The funeral director cannot obtain a burial permit without the completed death certificate and is subject to heavy penalties if he proceeds with a funeral without a burial permit.

In 1947 the legislature enacted the following statute:

**366.20 Reporting deaths required; penalty.** (1) All physicians, authorities of hospitals, sanatoriums, institutions (public and private), convalescent homes, authorities of any institution of a like nature, and other persons having knowledge of the death of any person who shall have died under any of the following circumstances listed below, shall immediately report such death to the sheriff, police chief, or coroner of the county wherein such death took place:

(a) All deaths in which there are unexplained, unusual, or suspicious circumstances.

(b) All homicides.

(c) All suicides.

(d) All deaths following an abortion.

(e) All deaths due to poisoning, whether homicidal, suicidal, or accidental.

(f) All deaths following accidents, whether the injury is or is not the primary cause of death.

(g) When there is no physician in attendance.

(h) When a physician refuses to sign the death certificate.

(2) Any person who shall violate this section shall be punished by a fine of not less than $5, nor more than $200, or by imprisonment not less than 30 days nor more than 3 months (1947, ch. 269).

The statutes are rather vague about who shall sign the medical certification of death under the circumstances mentioned above, but it is generally assumed that a physician was in attendance during the time or shortly after death occurred, in which case such physician should fill in, to the best of his knowledge and belief, the medical certification over his personal signature.

Where an autopsy was performed to determine the cause of death when no physician was in attendance before death occurred, "the autopsy surgeon (pathologist) could properly make the death certificate," according to an opinion of the Attorney General (December 7, 1951). However, when a physician was in attendance, he—and not the physician performing an autopsy—should make and sign the medical certification on the death certificate.

When no physician was in attendance and no physician is willing on his own responsibility, based on knowledge and belief, to enter the medical certification of the cause of death over his personal signature, the local registrar (*i.e.*, the city health officer or

the register of deeds) is authorized to insert the facts relative to the cause of death from the statement of relatives or other competent persons. The permit for burial shall be issued upon such information.

Frequent questions as to the final disposition of a fetal death or stillbirth are submitted to the State Board of Health; and based on the lack of specific statutory provisions, the following procedure has been established. The decision concerning the final disposition of a fetal death, regardless of the period of gestation involved, is the prerogative of the parent or parents. The hospital authorities or the attending physician is authorized to make or direct such final disposition as expressed by the parent or parents. A burial permit must be obtained when the fetal death has occurred during or after the twentieth week of gestation, and a fetal death certificate must be issued and signed by the attending physician.—PAUL WEIS, *Assistant State Registrar.*

## SPRING MEETING OF WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY

The Wisconsin Society of Obstetrics and Gynecology will hold its spring meeting on May 22 at the Northland Hotel, Green Bay. All physicians interested in the subjects of obstetrics and gynecology, even though not members of the society, are cordially invited to attend.

### PROGRAM

A. M.

9:00 *Slides on Gynecological Pathology and Fetal Anomalies*
Harris Weisse, M. D., Plymouth

9:30 *Comparison of the Very Young and Elderly Primigravidae*
G. F. Burgess, Jr., M. D., and F. J. Hofmeister, M. D., Milwaukee

10:00 *Gynecological Surgery in the Aged*
P. E. Carroll, M. D., and F. J. Stoddard, M. D., Milwaukee

10:30 *Management of Pathological Vertex Presentations*
Alex Krembs, M. D., Milwaukee

11:00 *Report from the Wisconsin Maternal Mortality Survey*
T. A. Leonard, M. D., Madison

11:30 *The History of the Society*
R. S. Cron, M. D., Milwaukee
J. W. Harris, M. D., Madison

P. M.

12:15 *Dinner*

1:30 *Choriocarcinoma and Related Problems*
Guest speaker, Marvin Blackbourn, M. D., pathologist, Bellin Memorial Hospital, Green Bay

2:00 *Orthopedic Problems in the Newborn*
Guest speaker, James W. Nellen, M. D., orthopedist, Green Bay

2:30 *Annual Business Meeting*

# Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and
J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

## REPORT OF A CASE*

*History.* This girl was born in 1936, the result of a normal pregnancy and delivery. She talked, walked, and teethed at a normal age. She went to school at the expected time but repeated first grade because she could not read well. She was first seen in the University Hospitals in 1944, at which time she was 8 years of age. She came here because vomiting and abdominal distress developed a few weeks before.

*Physical Examination.* The examination was not remarkable, except for findings of moderate pallor. The liver and spleen were considered of normal size. There was no lymphadenopathy or icterus.

*Laboratory Examination.* The first blood count showed a red blood cell count of 3,130,000, with a hemoglobin of 9 Gm. per cent and a reticulocyte count of 3 per cent. The red blood cell size, hemoglobin content and concentration were normal. The white blood cell count was 4,000, with a differential which was not remarkable. The chest x-ray was negative. The bone age by x-ray was 8 years. The gastrointestinal series was interpreted as showing pylorospasm.

*Second Admission.* In 1947, at the age of 10, she was again admitted to this hospital.

*Physical Examination.* She was small for her age and pale. The spleen was not palpable.

*Laboratory Examination.* The blood pressure was 118/56. The laboratory examinations showed anemia, leukopenia, a normal nonprotein nitrogen and urinalysis. There was free acid in the gastric contents after histamine administration. A bone marrow aspiration showed 30 per cent erythroid cells. The gastrointestinal x-ray was normal. The skull was osteoporotic. The bone age by x-ray was 7½ years.

*Course.* She was given her first blood transfusion at this time. She was seen repeatedly through the next several years and showed a similar blood picture. Her growth and mental development were retarded. She became very dependent on her parents and would complain of pain and vomit when they would leave her for even a brief time.

A bone marrow biopsy performed in February 1950, after many transfusions had been given, was interpreted as showing mild hyperplasia. The fecal urobilinogen was 255 mg. per 24 hours at a time when the hemoglobin was around 8 Gm. The Coombs' test was negative. The reticulocyte count was 12.5 per cent. The patient was splenectomized; the spleen weighed 120 Gm. The subsequent course was not materially different from that during the presplenectomy period.

Because of the retarded physical and mental development and the osteoporosis and anemia, it was felt that there might be some metabolic abnormality such as pituitary dwarfism. A trial of testosterone and estrogen was not helpful nor was the multitude of antianemic medications. The patient was given iron salts orally and parenterally. She was given vitamin $B_{12}$, folic acid, pyridoxine, vitamin C, and thyroid extract. In December 1952 her father died. Shortly thereafter she began to lose weight. She was seen in the Outpatient Department in April. The urine glucose was 4 plus. At this time she had had a total of over 200 blood transfusions, perhaps closer to 400. She was admitted to the hospital on April 21, 1953. The blood sugar was 345 mg. per cent, and carbon dioxide was 14 milliequivalents per liter. The urine was strongly positive for acetone. The hemoglobin was 7 Gm.; the white blood cell count was 10,000. The patient was conscious and talking at one moment; and 15 minutes later the respirations became gasping and weak, and the patient died.

### Clinical Discussion

**Dr. J. J. Lalich:** We have an interesting case to present today. The history in the protocol indicates that some difficulty was encountered in establishing a diagnosis. The analysis which follows will resolve some of these questions and also point out some interrelationships between different diseases. The case will be discussed by Doctor Schuster.

* From the University Hospitals and University of Wisconsin Medical School.

**Dr. B. Schuster:** The patient under discussion was apparently a normal infant. While in the first grade, she could not read well and therefore had to repeat the school year. She was seen for the first time at the age of 8 because of nausea, vomiting, and abdominal distress. A physical examination at that time was not remarkable except for findings of pallor. There was no hepatosplenomegaly and no lymphadenopathy or icterus. The first blood count revealed a red blood cell count of 3,130,000 with a hemoglobin of 9.0 Gm. per cent and a reticulocyte count of 3 per cent (2 per cent normal). The red blood cell size, the hemoglobin content and concentration were within normal limits. The white blood cell count was 4,000, with a normal differential. Chest and bone x-rays were normal. The gastrointestinal series was interpreted as showing pylorospasm. Thus, at the first admission, this child had a normochromic, normocytic anemia and a mild leukopenia.

Two years later she re-entered this hospital at the age of 10, when she was believed to be small for her age. Again, the spleen was not palpable. The child was pale. The laboratory examinations revealed anemia and leukopenia, as they had on the first admission. The nonprotein nitrogen and urinalysis were within normal limits, and there was free acid in the gastric contents after histamine administration. I presume that the acidity of the gastric contents was tested to rule out pernicious anemia; however, many outstanding hematologists, including Dr. Louis Diamond, contend that pernicious anemia does not occur in children. Wintrobe states that pernicious anemia occurs in late adult life and is extremely unusual in children; however, a few cases have been reported in the literature on infants and children. A bone marrow aspiration showed 30 per cent erythroid cells. I assume from the protocol that no abnormalities were noted. A gastrointestinal x-ray was normal. The skull was osteoporotic, and the bone age was 7½ years. Thus, we see at the time of the second admission that there is evidence of physical retardation, plus osteoporosis and delay in bone growth. The anemia and leukopenia persisted after 2 years, and a bone marrow aspiration showed 30 per cent erythroid cells, which is within normal limits.

At this time we might consider the possibility of anemia due to blood loss, destruction of cells, or deficient blood formation. There has been no mention of icterus or of episodes suggesting hemolytic crisis during the course of the 2 years during which this child was ill. The reticulocyte count on the first admission was slightly elevated but not remarkable. No evidence of an acute or chronic hemorrhage has been noted; thus, blood loss anemia is not suggested. The absence of hepatosplenomegaly or icterus and the failure of any episode suggesting hemolytic crisis do not weigh strongly in favor of a hemolytic anemia. There is the distinct possibility of an anemia due to defective blood formation. The anemia and leukopenia, in the absence of other findings, make this a distinct possibility. Subleukemic leukemia is also a consideration; however, the absence of abnormal cells in the bone marrow or the peripheral smear weighs heavily against this condition. Wintrobe, in his book, *Clinical Hematology*, describes a case of thymic tumor which produced a hypoplastic type of anemia which was refractory to all forms of antianemic therapy. After removal of the tumor, the anemia promptly cleared up. Another consideration is that of myelofibrosis or osteosclerosis; however, the 2 sets of bone x-rays taken in 1944 and in 1947 do not suggest this condition. Another possibility at this time is exposure to benzol, gold compounds, chloramphenicol, or x-rays; however, there is no history of such exposure. Another consideration is an anemia which is associated with various types of infection or chronic disease where hematopoietic activity is depressed; however, there is nothing to suggest that any chronic infectious state exists. I presume that this has been investigated thoroughly.

The patient received her first blood transfusion in 1947 during the second admission. She was seen repeatedly for the next several years and showed a similar blood picture. This suggests that the anemia was refractory to treatment over the course of several years. Her physical and mental development was retarded, and she became very dependent upon her parents. She complained of pain and vomited whenever her parents would leave her for a short time. The physical and mental retardation might possibly be due to the chronic anemic state and malnutrition. Repeated hospitalization probably made the child tense and fearful and secure only when her parents were present. A bone

marrow biopsy performed in February 1950, after many transfusions had been given, was interpreted as showing mild hyperplasia. Again no mention is made of abnormal cells. This would tend to rule out the leukemias. The fecal urobilinogen was 255 mg. per 24 hours at a time when the hemoglobin was around 8 Gm. per cent. The finding of a normal fecal urobilinogen in the face of a low hemoglobin would suggest that this anemia is not due to hemolysis. Thus, conditions such as Lederer's anemia, sickle cell anemia, congenital hemolytic anemia, and thalassanemia are ruled out. The Coombs' test was negative; if it were positive, acquired hemolytic anemia would have to be considered strongly. The elevation of the reticulocyte count indicates that the bone marrow is attempting to produce more red blood cells. This finding certainly favors a diagnosis of hemolytic anemia; however, too many other factors are against it. The reticulocyte count may be elevated in an anemia with an aplastic or hyperplastic bone marrow, although this is not usual. Dr. C. H. Smith, in *The Journal of Pediatrics*, October 1953, states that in hypoplastic anemia the cellular components of the bone marrow cannot be accurately correlated with the peripheral blood picture.

The patient was splenectomized; and the spleen, when removed at operation, was of normal weight. Since the subsequent postoperative course was not materially different from the presplenectomy period, this is certainly not a case of hypersplenic anemia. Because of the retarded physical and mental development, the osteoporosis, and the anemia, it was felt that this case might well represent some metabolic abnormality such as pituitary dwarfism. A trial of testosterone and estrogen was not helpful. The patient was given many antianemic preparations, such as iron salts orally and vitamin $B_{12}$, folic acid, pyridoxine, vitamin C, and thyroid extract parenterally. She was completely refractory to all of these treatments.

In 1952, 8 years after she was seen here for the first time, the patient was admitted to the hospital because of weight loss and listlessness following the death of her father. At that time the urine was 4 plus for glucose. The blood sugar was 345 mg. per cent, and the carbon dioxide was 14 milliequivalents per liter. The urine was strongly positive for acetone. Since the child had had over 200 blood transfusions, it may be surmised that a secondary or an exogenous hemachromatosis had produced the diabetes. On this admission the hemoglobin was 7 Gm., and the white blood cell count was over 10,000.

Thus, in review, we see a person who through the course of 8 years has had a normochromic, normocytic anemia, with a bone marrow which was either normal or hyperplastic and an anemia which was completely refractory to treatment. There was never any evidence of icterus. The spleen, liver, and lymph nodes were not palpable, nor was there any suggestion of hemolytic crisis throughout the course of her illness. It is my belief that the patient was suffering from a primary refractory anemia for many years, during which time she received over 200 blood transfusions. She eventually developed a secondary hemachromatosis, with resulting pancreatic fibrosis and diabetes mellitus. There was no effect on the anemia following splenectomy; no evidence of endocrine disorder or tumor was found.

The absence of enlargement of the lymph nodes, liver, and spleen and the inability to find any cause (including that of exposure to toxic substances or x-ray) for the condition make the diagnosis of a primary refractory anemia with a hyperplastic bone marrow tenable.

**Doctor Lalich:** Are there any other questions?

**Dr. E. H. Johnson:** Is there any correlation between hemoglobin, fecal urobilinogen, and icterus?

**Dr. R. F. Schilling:** Excessive rates of hemolysis may occur in the absence of icterus, but from a clinical point of view it is safe to rule out hemolytic disease if the 24-hour urobilinogen excretion is normal as determined on a 4-day collection of stool. The fecal urobilinogen determination using Watson's 4-day quantitative technic is probably the best clinical determination for the establishment of the excessive rates of hemolysis.

**Dr. H. J. van Baaren:** Were any platelet counts made?

**Doctor Schilling:** Numerous counts were made and were essentially normal.

**Doctor van Baaren:** Were the leukocytes ever elevated?

**Doctor Schilling:** Only occasionally.

**Doctor van Baaren:** What were the white blood cell counts before and after splenectomy?

**Doctor Schilling:** For a few days after splenectomy, the white blood cell count was elevated to 10,000, but within a couple of weeks it had again fallen to slightly below 5,000.

**Doctor van Baaren:** What is the surgical pathology report on the spleen?

**Doctor Schilling:** Nothing other than acute congestion.

**Doctor Lalich:** We shall have Doctor Baker present the x-ray reports.

**Dr. R. Baker:** The films revealed a generalized osteoporosis, especially conspicuous in the skull. Films of hand and wrist for bone age revealed an age of 13½ years at 15 years of age.

**Doctor Lalich:** We shall have Doctor questions, we shall present the autopsy findings.

### Necropsy Findings

(University Hospitals 53:104)

**Doctor Lalich:** This was a short, 136 cm., emaciated body of a 17-year-old female. The teeth were carious. The skin was of a yellowish-brown color, and the pigmentation was more intense on the lower extremities. The heart weighed 140 Gm. The coronaries, the large vessels, and the myocardium were normal. There was minimal lipid infiltration of the aortic and mitral valves. The lungs weighed 170 and 140 Gm., with only congestion and minimal edema. The liver weighed 1,250 Gm., was a rusty brown color, and cut with increased resistance. On cut surface, the organ presented a perilobular collection of brownish pigment. The adrenal glands each weighed 2 Gm. (normal combined weight is 10 to 12 Gm.). The thyroid weighed 10 Gm. (30 Gm. normal). The ovaries and uterus were of normal size. The kidneys weighed 145 and 140 Gm. On examination, nothing other than pallor and a yellowish-brown discoloration of the parenchyma was evident. The pancreas was grossly normal in size. Interestingly enough, the bone marrow specimens from the lumbar and sternal areas were of the expected red color. The brain weighed 1,100 Gm. and was normal. In view of the suspected pituitary disease in this person, it was important to examine this organ. It was found to be of normal size. There was only a 0.1 cm. cyst in the pars intermedia, which is a common finding of no functional significance. The principal microscopic findings were the collections of hemosiderin in the liver, pancreas, and adrenal glands. In association with the hemosiderin, there was moderate periportal fibrosis of the liver lobules with atrophy and fibrosis of the pancreatic lobules. It was not possible to demonstrate either hyalinization or degeneration of the pancreatic islets. There were cortical nodules observed in both adrenals, with collections of hemosiderin in the reticular zone. The skin contained increased hemosiderin in the basal layer of the epidermis. In agreement with the previous biopsy studies of the bone marrow, we also observed moderate hyperplasia of both the erythroid and myeloid elements. There were many hemosiderin-containing phagocytes in the bone marrow. The megakaryocytes were normal.

In conclusion, we believed this to be a case of refractory anemia which required many blood transfusions, which were responsible for the excessive quantities of hemosiderin observed in the liver, pancreas, skin, and adrenal glands. Associated with the collections of hemosiderin, there was also fibrosis in the liver and the pancreas. The destruction of the pancreatic tissue eventually resulted in a terminal diabetes mellitus. This is, therefore, a case of transfusional hemochromatosis in a person with a refractory anemia.

In connection with the sequence of events which was observed in this case, I wish to present a recent report by Higginson *et al.* from *The American Journal of Pathology*, Volume 29, page 779, which deals with the relationship between hemosiderin collection and parenchymal destruction. Gillman and Gillman have inferred that the hepatic fibrosis is secondary to and probably the result of hemosiderin accumulation in the tissues. The observations of Higginson dispute this theory because they were unable to show any correlation between the quantitative accumulation of hemosiderin in the liver and the degree of hepatic fibrosis. They also point out that hepatic siderosis, idiopathic hemachromatosis, and transfusional hemosiderosis possess gross and microscopic differences and suggest that other factors besides the retention of hemosiderin are re-

sponsible for the parenchymal destruction and the associated fibrosis which may be observed in these different diseases.

**Doctor Schilling:** In regard to the interpretation of a Coombs' test on patients in whom there is suspected hemolytic anemia, I would like to say that a positive Coombs' test is strong evidence in favor of acquired hemolytic anemia; but a negative Coombs' test should not be interpreted as evidence against acquired hemolytic anemia. As regards the morphologic characteristics of the bone marrow, it should be noted that a physiologically hypoactive marrow may have the characteristics of hyperplasia, morphologically speaking.

# *Reminder:* On Circuit Teaching Programs

If you have not already done so, sign up for the circuit teaching programs listed below which are nearest your home. Registration, $6.00, including dinner. (For the Upper Peninsula two-day session, registration of $5.00 to be paid at time of attendance. Do not send check to the State Medical Society when you register).

## *May*

| May 25 | May 26 | May 27 |
|---|---|---|
| Chippewa Falls | Pinecrest (Iron River) | Rhinelander |

**TREATMENT OF COMMON SKIN LESIONS:** Garrett A. Cooper, M.D., Madison

**ENDOCRINE THERAPY IN GYNECOLOGIC DISORDERS IN RELATION TO CANCER:** Edwin J. DeCosta, M.D., Chicago

**MODERN MANAGEMENT OF HYPERTENSION:** Henry A. Schroeder, M.D., St. Louis

**A REVIEW OF NEUROLOGICAL SURGERY:** Henry Schwartz, M.D., St. Louis

## *June*

| June 16 | June 17 | June 18 |
|---|---|---|
| Racine | Elkhart Lake | Menominee, Mich. |

**CURRENT THERAPY IN THE TREATMENT OF TOXEMIAS:** Allan C. Barnes, M.D., Cleveland

**RHEUMATOID ARTHRITIS:** Edward F. Rosenberg, M.D., Chicago

**MEETING PROBLEMS OF PREMATURITY IN GENERAL PRACTICE:** James P. Conway, M.D., Milwaukee

**WHAT SURGERY HAS TO OFFER IN PULMONARY DISEASE:** Joseph W. Gale, M.D., Madison

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## *Registration Blank*

(Detach and Mail with Check, Payable to State Medical Society of Wisconsin. Mail to Box 1109, Madison, Wisconsin)

CHECK THE CLINICS YOU WILL ATTEND: $6.00 per clinic except for Menominee, Michigan. (For that meeting, $5.00 paid at time of attendance).

May 25: Chippewa Falls ____
May 26: Pinecrest ____
May 27: Rhinelander ____

June 16: Racine ____
June 17: Elkhart Lake ____
June 18: Menominee, Michigan ____

# . . . . THE PRESIDENT'S PAGE . . . .

THE legislative hopper in Washington is filling up, and the inexorable grinding process is beginning. Soon a multitude of menus and mixtures will emerge, each one being guaranteed by its sponsors to be the one true elixir of life which will cure our economic, sociologic, and political ills. Some of these will, no doubt, be both palatable and digestible just as they come from the mill. Others will need rehashing and recooking to make them palatable and digestible. But some will be so indigestible that no amount of rehashing will make them really edible. And it is in this category, I venture to guess, that we will find those bills that are designed to continue or expand the use of the Veterans Administration medical facilities for the care of nonservice-connected disabilities.

The A.M.A. opposes such legislation. And it is certain that, for voicing their opposition, "The Doctors" will be accused of having purely personal and mercenary motives. This is very unfortunate because (1) it is definitely not true; and (2) it will becloud the issue and hamper a logical discussion of the basic problem; viz., the role and responsibility of government and of the individual in matters of health.

Few will deny that government does play a role and does have a responsibility in relation to some matters of health. Neither will anyone deny that government has a tremendously large responsibility towards service-connected disabilities. But the nonservice-connected conditions pose quite a different problem. Look at it from these points of view:

1. The prime purpose of military combat education is to teach an individual how to survive the various hazards to which he may be subjected, as well as teaching him a multitude of methods for killing his fellow man. This emphasis on personal responsibility for one's own welfare is all to the good and, as a matter of fact, is quite in line with what many physicians have long maintained; *i.e.*, that no health program can succeed unless it envisions and enlists the personal interest of individuals. But the difficulty about military training and combat education is that this desirable emphasis on personal responsibility is overbalanced by the necessity of suppressing individuality for the sake of mass action.

Would it not be better, then, to take a long-range view of the situation and try to devise methods of preserving this feeling of personal responsibility rather than the feeling of "first, a veteran and Uncle Sam will take care of you; second, a citizen"?

Should we not, in other words, expand our efforts at education and job training for civilian life in the hope that the best aspects of military training can be carried over into the peacetime life we all look forward to with such longing?

2. It is highly improbable that there will be a marked reduction in the number of young men in the armed forces for many years to come; in fact, universal military training is a distinct possibility within the next few years. If this type of legislation should pass, there will be an ever-increasing proportion of our young, physically fit, male population that has come through military service without any injury, either physical or mental, and will be entitled to free medical care through the rest of life. At the same time, those young men who, through no fault of their own, are classed by the Government as unfit for military service and, hence, presumably at least, less robust and less able to compete in civil life, are told that they must fend for themselves.

3. If this type of discriminatory legislation should be enacted, why should it be confined to giving away medical services? The Government owns enormous stocks of surplus farm products which are doing no one any good where they are, so why not give them away to veterans also—"but not to the little 4–F who lived down the lane."

To anyone who has a service-connected disability with strong presumption of service connection, give the best medical care that can be found and give it without stint, at government expense if he requests it.

To anyone who was not hurt by his military service, give the best medical care that can be found and give it without stint, at his own expense if he is able to pay and through recognized local assistance agencies if he is without adequate means.

Thus, we can be building a stronger and more self-reliant civilization rather than one that is increasingly dependent upon government.

H Kent Tenney M.D.

# THE WISCONSIN MEDICAL JOURNAL

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# « « « EDITORIAL » » »

## Examinations: A Headache or an Opportunity?

When appointment schedules break down under pressure of hospital rounds, office calls, and emergencies, the average physician's slight aversion to the growing demand for "periodic examinations" becomes understandable. Cancer detection, the program on tuberculosis, W.I.A.A., and school health all chant the slogan of early diagnosis and periodic examinations. Under such pressure, the average physician is sorely tempted to tell his patient: "You feel fine, you look fine, what makes you think you need a checkup?" This may satisfy the patient, who didn't exactly look forward to having his prostate examined, anyway; but is it the best answer, after all? If even one patient dies of cancer after a polite brushoff to his request for a physical examination, there will be a lot of tongue wagging about the "poor type of medical care being given these days."

For years, the medical profession has subscribed to the thesis that early diagnosis is the best way of controlling disease. Early diagnosis can only mean a careful history and an adequate examination. To be sure, in some ways the public has been overeducated on early prevention of disease. In certain quarters, enthusiastic lay groups suggest examination programs which are entirely unreasonable. Suggestion of a "full examination for $3" is the kind of approach which necessitates revised public thinking. It is up to the State Medical Society and its public relations programs to redirect such loose thinking. Such efforts require the full support of all physicians, and their cooperation in providing examinations at reasonable charges.

There are many examination programs which demand the thoughtful support of the profession. Some of these are examination of high school athletes, examination of school employees (partially paid for in many instances by school funds), and examination of pupils prior to entrance into school. All afford opportunities for good health education as well as good public relations. Added to these is the necessity for examining persons who are not reached by well-organized programs of health examination.

The usual complaint that it "takes time" is neither valid nor justified. Just a few minutes of sincere interest and explanation of procedures in terms which nonprofessional people can understand are all that are needed to make the patient

feel that he is being received as a partner in the goal of good health rather than as a nuisance to the doctor whose advice he sought.

It should not surprise the reader that in some respects public approval of the medical profession has been on the wane during the past several years. It behooves every physician to recapture some of the public love of the revered "personal physician" by making sure that his examination reflects a concern of his heart as well as his mind.

## Sanatorium Care

Sanatorium care is essential in the therapy of active tuberculosis. The patient can be isolated promptly to reduce the hazard of continued exposure of his family and friends. Rest and education in the various problems of tuberculosis can be secured more satisfactorily in a group where all patients have similar problems of a chronic and infectious disease. The proper medical care of active tuberculosis has become a very highly specialized branch of medicine, and the patient has the benefit of such supervision within the sanatoriums. To advise any alternative to sanatorium care of active tuberculosis is not compatible with standards of ideal care for active tuberculosis either from the standpoint of the individual or the broader aspects of public health. In Wisconsin we are fortunate to have adequate sanatorium beds so that no patient need be denied the opportunity for the best care available. Physicians are urged to encourage the use of these facilities and to assist with patient care and supervision after sanatorium care has been provided.

*(A statement prepared by Helen Dickie, M. D., for the Division on Tuberculosis and Chest Diseases)*

## RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, October 23, 1953:

| *Name* | *School of Graduation* | *Year* | *Address* |
|---|---|---|---|
| Althaus, Charles F. | University of Buffalo | 1946 | Hazel Green. |
| Atkinson, Charles T. | Howard University | 1944 | 703 West Walnut, Milwaukee. |
| Austin, Stephen Drake | Harvard University | 1947 | Bellin Building, Green Bay. |
| Brown, Henry | University of Pennsylvania | 1944 | 1300 University Avenue, Madison. |
| Conlon, Harold Jay | University of Cincinnatti | 1945 | 310 Chestnut Street, Eau Claire. |
| Conrad, Gladys P. K. | University of Wisconsin | 1947 | 2103 Laurel Avenue, Eau Claire. |
| Dowding, Charles H., Jr. | Marquette University | 1946 | 4410 West Roosevelt Drive, Milwaukee. |
| Floersch, Adrian J. | Creighton University | 1948 | First National Bank Building, Glencoe, Minnesota. |
| Freeman, William S. | Northwestern University | 1949 | 407 Prospect Street, Beloit. |
| Garland, Thomas F. | University of Wisconsin | 1951 | Velva, North Dakota. |
| Grauer, Curt Gerhard | Northwestern University | 1950 | 400½ Third Street, Wausau. |
| Harris, Maurice Daniel | Long Island College | 1926 | 1240 West Windlake Avenue, Milwaukee. |
| Herrington, Roland E. | Marquette University | 1946 | 1821 West Wisconsin Avenue, Milwaukee. |
| Holzgrafe, Robert E. | Medical College of Virginia | 1949 | 3618 Branting Lane, Milwaukee. |
| Howlett, James Robert | University of Arkansas | 1946 | American Legion Hall, Hartland. |
| Kepler, Milton Oliver | University of Syracuse | 1949 | Medical Center, Cuba City. |
| Kiekhofer, William | Yale University | 1951 | 1300 University Avenue, Madison. |
| Knoblock, Dolores E. | University of Illinois | 1950 | 1104 North Spaulding, Chicago, Illinois. |
| Large, Hiram Lee, Jr. | Vanderbilt University | 1942 | 1119 Kenilworth Avenue, Charlotte, North Carolina. |
| Levine, Victor | Rush Medical College | 1929 | 30 North Michigan Avenue, Chicago, Illinois. |
| Manier, James Wyche | Vanderbilt University | 1949 | 1300 University Avenue, Madison. |
| Muldowney, John J. | University of Illinois | 1946 | Veterans Administration Hospital, Wood. |
| Myers, Wilbert Earl | University of Nebraska | 1951 | 104 South Main, Fond du Lac. |
| Peterson, John Cyril | Vanderbilt University | 1931 | 721 North 17th Street, Milwaukee. |
| Pischke, Eugene F. | University of Nebraska | 1951 | 328 East Main Street, Platteville. |
| Ramey, Charles A. | University of Illinois | 1945 | 217 West Main, Staunton, Illinois. |
| Rosenholtz, Burton | University of Minnesota | 1921 | 1560 North Prospect Avenue, Milwaukee. |
| Stubenrauch, Gerald | Temple University | 1949 | Veterans Administration Center, Wood. |
| Walker, James Haward | University of Maryland | 1941 | 1112 Virginia Street East, Charleston, West Virginia. |

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Madison, October 23, 1953.

| *Name* | *School of Graduation* | *Year* | *Address* |
|---|---|---|---|
| Coleman, Ruth | University of Arkansas | 1951 | 1300 University Avenue, Madison. |
| Foley, David Vincent | Marquette University | 1952 | 3316 West Wisconsin Avenue, Milwaukee. |
| Jensen, Alfhild I. E. | University of Oslo | 1949 | 310 Chestnut Street, Eau Claire. |
| MacLean, Cyril Rankine | University of Toronto | 1933 | Theda Clark Memorial Hospital, Neenah. |
| Smythe, Gwendolyn S. | University of Wisconsin | 1952 | 3349 West 16th Street, Indianapolis, Indiana. |
| Venables, Albert J. | University of Alberta | 1943 | St. Luke's Hospital, Milwaukee. |

# Distribution of Gamma Globulin in 1954

## 1. AGAINST POLIOMYELITIS

**GENERAL CONSIDERATIONS:** It has not been possible to demonstrate that the use of gamma globulin during 1953 in "family contacts," as a prophylaxis against poliomyelitis, was of definite value in preventing cases or in reducing the incidence or severity of paralysis. It is believed that its value when used for mass immunization in counties of high incidence was decreased by delaying the immunizations until a high "critical incidence" existed in the area. For these reasons it has been recommended that during 1954 gamma globulin be used early, without waiting for a high incidence, and that its use be limited to group immunization programs rather than for "family contacts."

**SUPPLY OF POLIOMYELITIS GAMMA GLOBULIN:** It has been estimated that, on the basis of a recommended dosage of 0.20 cc. per pound of body weight, Wisconsin will have a sufficient supply of gamma globulin in 1954 to furnish approximately 29,000 immunizing doses. This number of doses is based upon the average weight of children under 16 years of age.

**DISTRIBUTION POLICY: In cooperation with the State Medical Society of Wisconsin, the State Board of Health has drafted and approved the following policy for distribution of poliomyelitis gamma globulin in Wisconsin during 1954:**

**1. As long as the supply is available, gamma globulin will be made available to any physician in Wisconsin on request for group immunization of 10 or more children under 16 years of age and for pregnant females.**

**2. No more than one immunizing dose based upon 0.20 cc. per pound of body weight will be made available for any child during the current season.**

**3. It is recommended that the physician should not provide the immunizations until after July 1 unless the local poliomyelitis incidence is unusually high prior to this date. (It is believed that gamma globulin offers its greatest protection beginning with the second week after immunization and lasting for about 4 to 6 weeks. The period of highest incidence in Wisconsin occurs during the months of August and September in a rapidly ascending curve beginning about July 1).**

**4. Physicians will be required to furnish, on prescribed forms, the names, addresses, ages, and weights of the children in the groups of 10 or more to whom they plan to give the gamma globulin.**

**5. Distribution of gamma globulin will be by the district offices of the State Board of Health and the Bureau of Communicable Disease Control in Madison, beginning about June 1.**

**6.** *Gamma globulin will not be available for poliomyelitis prophylaxis to children in those counties where vaccine field trials are being conducted* **(stipulation of the National Foundation for Infantile Paralysis and the Public Health Service in order not to affect validity of vaccine studies),** *but will be available for pregnant females.*

**ADDITIONAL INFORMATION:** 1. Children for whom gamma globulin is obtained need not be contacts of known poliomyelitis cases.

2. Gamma globulin has not been shown to be effective in the treatment of poliomyelitis.

3. Gamma globulin is not available for use in household contacts of poliomyelitis.

## 2. AGAINST MEASLES AND INFECTIOUS HEPATITIS

**DISTRIBUTION POLICY: 1. Gamma globulin will be made available to any physician in Wisconsin on request for use in** *contacts* **of measles or infectious hepatitis.**

**2. In order to obtain the gamma globulin, the physician will need to furnish the name, age, and address of** *the patient* **as well as the name and age of** *each contact.* **Forms will be furnished by the Board of Health; however, telephone requests can be filled if the necessary information is provided.**

**3. Physicians may secure gamma globulin for use in prophylaxis against measles and infectious hepatitis from the nearest and**

most convenient distributing source. These agencies are the eight district offices of the State Board of Health located in Madison, Elkhorn, Fond du Lac, Sparta, Wisconsin Rapids, Green Bay, Chippewa Falls, and Rhinelander.

The seven city health departments acting as distributing agencies are those in Madison, Janesville, Kenosha, Milwaukee, Racine, West Allis, and Sheboygan. (Note: Gamma globulin for use against poliomyelitis will be available this year, *only* from the district offices of the State Board of Health and the Bureau of Communicable Diseases in Madison.)

4. Two (2) cc. will be furnished for each contact in measles and infectious hepatitis.

ADDITIONAL INFORMATION: 1. The recommended dosage of gamma globulin for prophylaxis in infectious hepatitis is 0.01 cc. per pound of body weight, up to a maximum of 2 cc. for any single individual.

2. Physicians may obtain 10 cc. of gamma globulin for use in pregnant females.

3. Gamma globulin is *not available* for use as a therapeutic agent.

## MARQUETTE STUDENT A. M. A. SPONSORS MEDICAL BALL

The annual medical ball of the Marquette chapter of the Student A. M. A. is being held on May 7. Tickets are $2 and may be obtained by writing the chapter, c/o Marquette University School of Medicine.

## BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1954 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referral be made by the family physician; but when this is not feasible, arrangements may be made by writing to the Bureau. Forms for the purpose of referral may be obtained from the Bureau of Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify for which clinic forms are wanted.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of the fact.

| | |
|---|---|
| Superior | April 28, 29 |
| Appleton | May 6, 7 |
| Fond du Lac | May 12, 13 |
| Chippewa Falls | May 20, 21 |
| Rhinelander | June 2, 3 |
| Lancaster | June 10 |
| Darlington | June 11 |

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

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# Society Proceedings

## Dodge

On February 25 the Dodge County Medical Society met at the Lutheran Hospital, Beaver Dam, to hear *Dr. Sture Johnson* of Madison talk on "Oral Tumors and Diseases." Doctor Johnson illustrated his talk with colored lantern slides.

Following the regular meeting, the members joined the Dodge County Auxiliary for refreshments.

## Fond du Lac

*Dr. John P. Docktor*, Milwaukee, spoke to 29 members of the Fond du Lac County Medical Society on February 25 at a dinner meeting held at the Elks Club in Fond du Lac. His subject was "Plastic Treatment of Benign and Malignant Lesions of the Face." Discussion by *Dr. Howard Mauthe*, Fond du Lac, and the speaker followed.

## Grant

The Grant Couny Medical Society met on February 11 in the Grantland Clubrooms, Lancaster, for a scientific discussion. Twenty-five doctors from the county were present for the meeting.

## Green Lake–Waushara

Ten members of the Green Lake–Waushara County Medical Society met for a business meeting on February 23 at the Berlin Memorial Hospital, Berlin. Besides discussing the regular business, the members saw a film on "Feeding Problems in Infants."

## Manitowoc

Members of the Manitowoc County Medical Society and the staff of Memorial Hospital, Manitowoc, held a joint dinner Wednesday noon, February 24, at the Hotel Manitowoc. *Dr. L. D. Sobush* led a panel discussion on "Rheumatic Fever." Other participants were *Drs. N. A. Bonner, Gerald A. Rau, R. F. Thorpe*, and *R. C. Puestow*.

Announced at the meeting were *Dr. C. G. Reznichek's* appointments from the Manitowoc Chapter of the Wisconsin Chapter of the American Academy of General Practice to committees to arrange for the state convention at Milwaukee, November 30 to December 1. Those appointed were *Dr. N. A. Bonner*, scientific program committee; *Dr. Charles E. Wall*, banquet and entertainment committee; and *Drs. Raymond G. Yost* and *Wallace S. Marshall*, scientific exhibits committee. Also appointed to state committees were Doctor Yost to the committee on hospital relations and Doctor Sobush to the committee on insurance.

## Marathon

*Dr. R. H. Quade*, Neenah, addressed the Marathon County Medical Society on February 23 at the Wausau Club on the subject, "Head Injuries."

The Society accepted four new members at the meeting. Thirty-six physicians attended..

## Pierce–St. Croix

Sixteen members of the Pierce–St. Croix County Medical Society met at the Dibbo Hotel, Hudson, on January 19 to hear Mr. Bargen discuss preschool examinations. New officers elected at the meeting were:

President—*Dr. F. B. Klaas*, East Ellsworth
Vice-President—*Dr. J. P. Healy*, New Richmond
Secretary–Treasurer—*Dr. P. H. Gutzler*, River Falls

The February meeting was held in Elmwood, where members heard *Dr. Charles M. Ihle*, orthopedic surgeon from Eau Claire, give a talk on "Disorders of the Shoulders and Knees."

## Polk

Seventeen members of the Polk County Medical Society were the guests of *Dr. V. C. Kremser*, Amery, on February 17 at Paradise Lodge, Balsam Lake. They heard Dr. E. S. Platou, clinical professor of pediatrics, University of Minnesota Medical School, and Dr. A. J. Schroeder, Minneapolis, discuss "Rh Factor and Exchange Transfusions." Their paper was illustrated by colored slides.

## Trempealeau–Jackson–Buffalo

On Tuesday, February 23, St. Joseph's Hospital, Arcadia, was the meeting place for the members of the Trempealeau–Jackson–Buffalo County Medical Society and the Woman's Auxiliary of the society. Following dinner, members and their wives heard *Dr. A. H. Gundersen* of La Crosse discuss "Urology."

## Walworth

*Dr. Robert A. Moses*, newly elected president of the Walworth County Medical Society, held a meeting of the society's officers at his home in Delavan on February 28 to discuss plans for the programs for the coming year. Other newly elected officers are vice-president, *Dr. George Truex*, Darien, and secretary-treasurer, *Dr. Glenn Smiley*, Delavan.

# SUSTAINED PENICILLIN LEVELS IN STREPTOCOCCAL INFECTIONS

". . . it has been shown that the treatment of streptococcic infections by adequate amounts of penicillin will prevent rheumatic fever . . . On the basis of our experience, we feel that BICILLIN for injection more nearly supplies the need than any other product available at present."[1]

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1. Breese, B. B.: J.A.M.A. *152*:10 (May 2) 1953
2. Welch, H.: Antibiot. & Chemo. *3*:347 (April) 1953
3. Stollerman, G. H., and Rusoff, J. H.: J.A.M.A. *150*:1571 (Dec. 20) 1952

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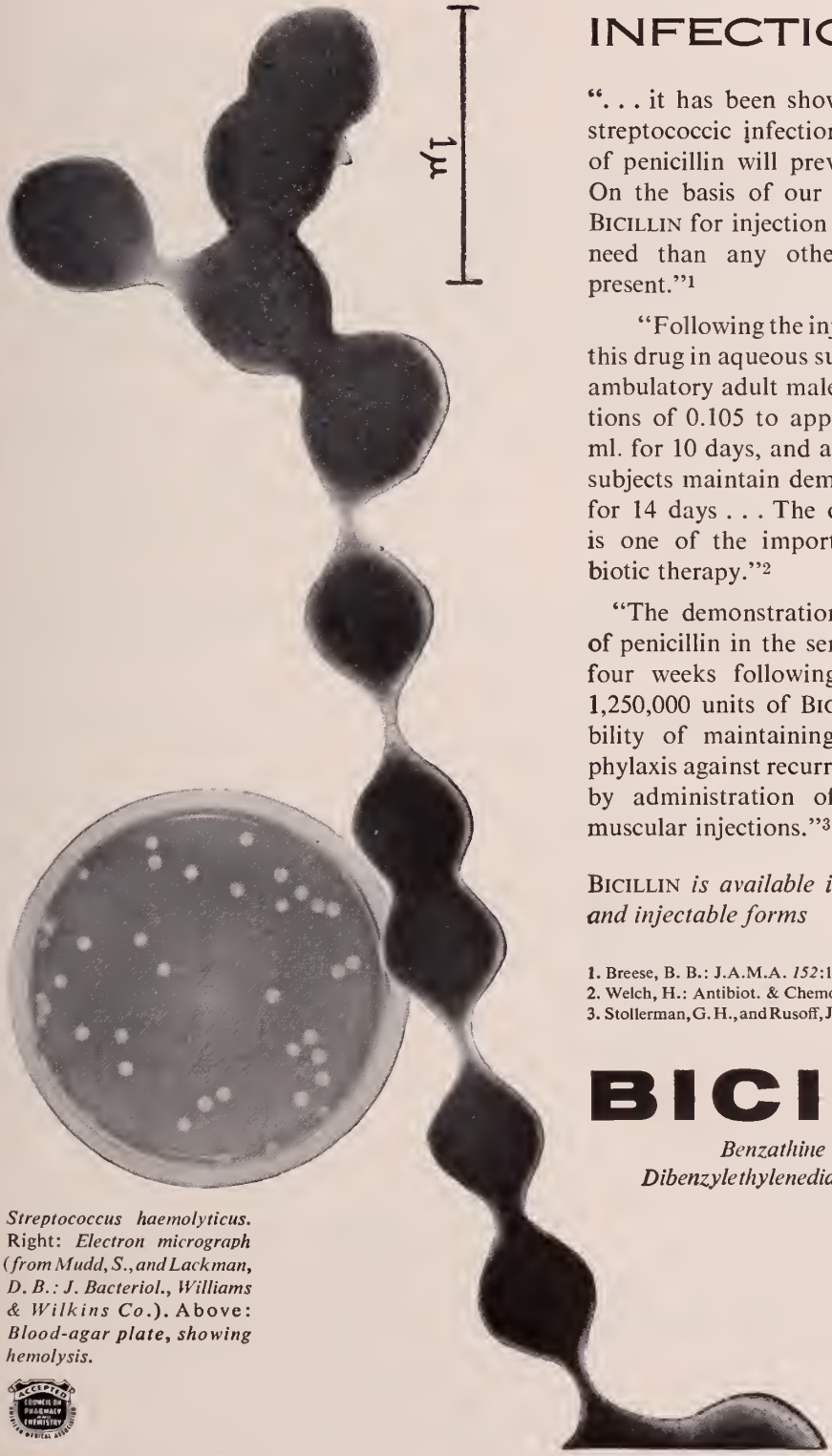


*Streptococcus haemolyticus.* Right: *Electron micrograph (from Mudd, S., and Lackman, D. B.: J. Bacteriol., Williams & Wilkins Co.).* Above: *Blood-agar plate, showing hemolysis.*

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### American Academy of General Practice Sheboygan Chapter

In February the Sheboygan Chapter of the American Academy of General Practice held a dinner meeting at Leon's in New Holstein for election of officers. *Dr. John E. Martineau* of Elkhart Lake was elected president; *Dr. Francis P. Larme* of New Holstein, vice-president; and *Dr. Lloyd J. Steffan* of Plymouth, secretary-treasurer.

*Dr. Friedrich Eigenberger* of Sheboygan showed slides of his South Seas tour.

Doctors were present from Manitowoc, Calumet, Outagamie, Fond du Lac, and Sheboygan counties. *Dr. Cyrus Reznichek* of Madison, the president of the Wisconsin Academy of General Practice, was present.

Doctor Martineau and *Dr. A. J. Brickbauer*, of Plymouth, received committee assignments.

# News Items and Personals

### Doctor Schlenker Returns from Service

After two years of army service, *Dr. L. T. Schlenker*, orthopedic surgeon, has reopened his office in Kenosha. Doctor Schlenker was graduated from Marquette University School of Medicine in 1947. He had an office in Kenosha for three months before entering military service in January of 1952. While in the service, he practiced orthopedic surgery at Fort Ord, California.

### Doctor Thimke Moves to Iowa

*Dr. H. E. Thimke* has left Shawano for a two-year residency in anesthesiology at the University of Iowa at Iowa City. He was associated with the Cantwell–Peterson Clinic in Shawano.

### Dr. Albin Sowka Opens Practice in Stevens Point

*Dr. Albin J. Sowka* recently arrived in Stevens Point and has associated with his uncle, *Dr. P. N. Sowka*. He is also a member of the staff of St. Michael's Hospital.

Doctor Sowka was just recently discharged as a major in the Army Air Force. He had served in the Far East as chief of surgery at a United States Air Force hospital in Japan and later as chief of surgery at Sampson Air Force Base, Geneva, New York. A graduate of Loyola University School of Medicine at Chicago, he had subsequent specialized training in surgery at St. Mary's of Nazareth Hospital, Chicago, and at the University of Illinois in Champaign.

### Whitehall Doctor Is A.M.A. Delegate to Scotland

*Dr. R. L. MacCornack* of Whitehall has been appointed to represent the American Medical Association at a meeting next summer of the British Medical Society in Scotland. Doctor MacCornack will travel to Glasgow for the meeting to be held July 5 to 9. He is president of the Community Hospital Board in Whitehall and is former Speaker of the State Society House of Delegates.

### Dr. Woodruff Smith to Leave Ladysmith

Ladysmith physician and surgeon, *Dr. Woodruff Smith*, has accepted an appointment as industrial physician with the Jones & Laughlin Steel Corporation at Pittsburgh, Pennsylvania.

Doctor Smith, who has been a member of the Wisconsin State Board of Health, has been in practice in Ladysmith since 1924.

### Dr. J. Francis Wilkinson Elected Chief of Staff at Oconomowoc Hospital

The formation of the permanent organization of the medical staff of Memorial Hospital at Oconomowoc has been announced by hospital officials.

The physicians composing the charter staff of the hospital include *Drs. John T. Riley* of Hartland; *William D. James, Joseph R. Matt, T. H. Nammacher, Albert F. Rogers, Peter B. Theobald, Donald C. Wilkinson, J. Francis Wilkinson, John D. Wilkinson, Philip M. Wilkinson, Owen C. Clark, A. J. Loughnan*, and *F. N. Peterson* of Oconomowoc; *Leonard C. J. Olson* of Delafield; *Raymond P. Welbourne* and *Felix H. Zimmermann* of Watertown; *Frank M. Scheele* of Waukesha; and *C. H. Kalb, Malcolm F. Rogers, Herman C. Schumm*, and *David J. Carlson* of Milwaukee.

Elected to head the new medical staff during the first year is Dr. J. Francis Wilkinson as president and chief of staff; Dr. T. H. Nammacher, vice-president; and Dr. Albert F. Rogers, secretary. Members of the executive committee, elected to serve with the above officers, are Drs. Leonard C. J. Olson and Raymond P. Welbourne. Doctor Wilkinson has appointed Dr. Peter B. Theobald as chief of the medical service, Dr. Raymond P. Welbourne as chief of the surgical service, and Dr. John D. Wilkinson as chief of the obstetrical service.

### Doctor Kagen Speaks to Hospital Group

*Dr. Marvin S. Kagen*, Appleton, was the speaker at a maternal and child health meeting for nurses and hospital administrators at the New London Community Hospital on February 4. He spoke about skin diseases and how drugs react on them and used colored slides to illustrate his talk.

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### Dr. Robert Jackson Enters Private Practice

*Dr. Robert D. Jackson* has opened his own office in Lancaster for the practice of medicine and surgery. He has been associated with *Dr. E. M. Houghton* for several years at the Lancaster General Hospital.

### Doctor Curreri Speaks to Platteville Group

*Dr. Anthony R. Curreri,* Madison, director of the Tumor Clinic at Wisconsin General Hospital, Madison, and associate professor of surgery at the University of Wisconsin, spoke to members of the Platteville chapter of the Wisconsin Alumni Association at the annual Founder's Day program on February 24. His subject for the evening was "Korean Experiences for the United States Surgeon General," and it covered his research made on substitutes for blood plasma.

In 1952, at the request of the United States Surgeon General, Doctor Curreri took a six weeks' tour of duty in Korea to study the problem of battle shock among United States soldiers and to check the effectiveness of present shock treatments.

### Doctors Bolger Give Talks

At a meeting of the Union School PTA study group, Waukesha, held on February 9, *Drs. J. Victor* and *James V. Bolger,* Waukesha, spoke to the group on conditions of the eye, ear, nose, and throat. They used slides to illustrate their talks.

## THIRD AND TWELFTH DISTRICTS NEWS

### Rock

The Rock County Medical Society and Auxiliary held a joint meeting at the Monterey Hotel, Janesville, on February 16. Following the dinner, Stephen E. Gavin, Jr., Madison, talked on "State Lobbying." Mr. Gavin is legal counsel for the State Society.

### Doctor Campbell Participates on Panel

*Dr. Ralph E. Campbell,* Madison, took part in the sectional meeting of the American College of Surgeons held at French Lick, Indiana, on March 15 to 17. He took part in a panel on gynecological procedures.

### Doctor Curreri Talks in Michigan

*Dr. A. R. Curreri,* associate professor of surgery at the University of Wisconsin Medical School and director of the Tumor Clinic, University Hospitals, recently took part in two medical meetings in Michigan. From February 18 to 20, Doctor Curreri attended the Central Surgical Meeting in Detroit, and on February 21 he spoke to the Mid-West Chest Club in Ann Arbor. The topic of his paper was "Significance of Pulmonary Coin Lesions."

## Dr. Stuart A. McCormick Attends Research Conference

*Dr. Stuart A. McCormick* left Madison on March 8 to attend a regional research conference of the American Psychological Association in Mexico City, Mexico. The theme of the conference was "Approaches to the Study of Human Personality."

## Wisconsin's Dean Middleton to Retire in 1955

W. S. MIDDLETON, M. D.

*Dr. William S. Middleton,* internationally renowned physician and dean of the University of Wisconsin Medical School since 1935, has informed the University of his plan to retire in June of 1955. He plans to devote his time to research. The dean is an acknowledged international authority on blood and cardiorespiratory diseases.

Born in Norristown, Pennsylvania, in 1890, Dean Middleton was graduated from the University of Pennsylvania School of Medicine in 1911; and he came to the University of Wisconsin shortly after his graduation. He served as an instructor of clinical medicine until 1915, when he was made an assistant professor. He was advanced to associate professor in 1923 and became a full professor in 1933.

He has served as president of the American College of Physicians and was only recently appointed vice-president of the Association of American Medical Colleges. Doctor Middleton was a captain in the Army Medical Corps in World War I; and during World War II, he served as a colonel in the U. S. Army Medical Corps, where he was chief consultant on internal medicine for all Allied troops in the European theater of operations. For that service he was awarded the Distinguished Service Medal and the Legion of Merit with oak-leaf clusters. Other high decorations included the Order of the British Empire and the French government's Croix de guerre with palms.

Doctor Middleton holds honorary doctor of science degrees from Cambridge University, England, and the University of Pennsylvania and is an honorary fellow of the British Royal Society of Medicine.

## Madison and Milwaukee Give Short Courses on Maternal and Child Welfare

Special short courses are being offered at Madison and Milwaukee by the State Medical Society's Division on Maternal and Child Welfare on the subject of saving more prematurely born babies. *Dr.*

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*Thomas V. Geppert*, Madison, a member of the division, will give instruction at St. Mary's Hospital, Madison; and *Dr. Kenneth J. Winters*, Wauwatosa, will give instruction at Milwaukee Maternity Pavilion, Milwaukee.

Representatives may be sent from any hospital outside of Madison and Milwaukee which reported caring for 30 or more prematurely born babies during 1952. Courses for physicians and nurses in Madison and Milwaukee may be scheduled later.

## Milwaukee

At the annual joint meeting of the Medical Society of Milwaukee County and the Wisconsin Heart Association held on February 11, three noted physicians spoke on degenerative artery disease. Those attending the meeting, which was held under the auspices of the Lucy Ann Doessel memorial fund of the Heart Association, heard Dr. James C. Paterson, London, Ontario, professor of medical research and lecturer in pathology at the University of Western Ontario; Dr. Nelson W. Barker, Rochester, Minnesota, head of the section of medicine at the Mayo Clinic and professor of medicine at the Mayo Foundation Graduate School of the University of Minnesota; and Dr. Jeremiah Stamler, research associate in the cardiovascular department of the Michael Reese Hospital Medical Research Institute, Chicago, Illinois.

## Doctor Peterman Addresses New Mexico Group

*Dr. M. G. Peterman*, Milwaukee, addressed the annual meeting of the Pediatrics Society of the State of New Mexico on March 29. The meeting was held in Santa Fe.

## Doctor Tenney Speaks in Milwaukee

*Dr. H. Kent Tenney*, Madison, spoke at a meeting of 75 delegates of the Community Welfare Council's Group Work and Recreation Division on March 9 in Milwaukee. Doctor Tenney spoke on the benefits of an athletic program in the family and in the development of children.

## Doctor Hirschboeck Addresses St. Catherine's Hospital Auxiliary

*Dr. John S. Hirschboeck*, dean of the Marquette University School of Medicine, addressed St. Catherine's Hospital Auxiliary and guests in Milwaukee on February 4 at the Auxiliary's fifth anniversary meeting. His topic was "Education Role of the Hospital." In his speech, Dean Hirschboeck said, "Many forget that the hospital, as a service and educational institution, is close to the home and the living situation." Doctor Hirschboeck outlined programs within the hospital which continue the education of staff members.


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## St. Luke's Has Staff Elections

*Dr. Robert S. Irwin,* Milwaukee, has been chosen chief of staff at St. Luke's Hospital for a two-year term. He succeeds *Dr. J. J. O'Hara. Dr. Walter P. Zmyslony* was elected secretary-treasurer, and *Dr. S. L. Chojnacki* is president-elect.

## Doctor Raine Reappointed to State Board of Health

*Dr. Forrester Raine,* Milwaukee, clinical professor of surgery at the Marquette University School of Medicine, has been reappointed by Governor Kohler to the State Board of Health. His term will end in February 1961.

## American Academy of Orthopaedic Surgeons Honors Milwaukee Surgeons

A Milwaukee surgeon was recently named president-elect of the American Academy of Orthopaedic Surgeons, and another was given a committee chairmanship. *Dr. Walter P. Blount* was elected president-elect to take office a year from now, and *Dr. Albert C. Schmidt* was elected as head of the national program committee.

## Milwaukee Oto-Ophthalmic Society

Dr. Myron Hipskind, who is chairman of the department of otolaryngology at Woodlawn Hospital, Chicago, spoke to the Milwaukee Oto-Ophthalmic Society on March 23 at the University Club, Milwaukee. In connection with his talk, he showed a colored film on vertigo-differential diagnosis.

## SOCIETY RECORDS

### New Members

J. A. Malone, 2806 South Herman Street, Milwaukee.

E. J. Sabljak, 2427 South 82nd Street, Milwaukee.

A. C Sanders, Jr., 1117B West Wright Street, Milwaukee.

J. J. Brennan, 945 North 12th Street, Milwaukee.

Jean C. Antonmattei, 4918 West Wisconsin Avenue, Milwaukee.

G. J. Martin, 161 West Wisconsin Avenue, Milwaukee.

W. R. Rose, 833 West Walnut Street, Milwaukee.

D. H. McDonald, Winneconne.

E. F. Peterson, 8031 Harwood Avenue, Milwaukee.

T. S. Lynch, 19 Jefferson Avenue, Oshkosh.

Harvey Monday, 19 Jefferson Avenue, Oshkosh.

J. R. Heersma, 650 South Central Avenue, Marshfield.

T. H. McDonell, 650 South Central Avenue, Marshfield.

B. C. Hindall, 717 Geneva, Lake Geneva.

R. W. Leiby, Jr., 1836 South Avenue, La Crosse.

H. F. Burich, 1836 South Avenue, La Crosse.

R. L. Fransway, 80 Sheboygan Street, Fond du Lac.

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Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, June 7
Surgical Anatomy & Clinical Surgery, Two Weeks, June 21
Surgery of Colon & Rectum, One Week, May 10
Thoracic Surgery, One Week, June 7
Esophageal Surgery, One Week, June 14
General Surgery, Two Weeks, April 26, July 26
Fractures & Traumatic Surgery, Two Weeks, June 7

GYNECOLOGY—Gynecology Course, Two Weeks, June 7
and OBSTETRICS—Vaginal Approach to Pelvic Surgery, One Week, May 24
Combined Course in Gynecology & Obstetrics, Three Weeks, April 19

MEDICINE—Two-Week Course, May 3
Electrocardiography & Heart Disease, Two Weeks, July 12
Gastroenterology, Two Weeks, May 17
Hematology, One Week, June 14

DERMATOLOGY—Two-Week Course, May 10

PEDIATRICS—Congenital & Rheumatic Heart Disease in Infants & Children, One Week, April 19 and April 26
Cerebral Palsy, Two Weeks, June 14

UROLOGY—Two-Week Course, April 19
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I. C. Neubauer, 4939 West Wells Street, Milwaukee.

A. J. Sowka, 745 Main Street, Stevens Point.

R. D. Wichmann, Eleva.

P. J. Bates, 214½ North Barstow Street, Eau Claire.

G. A. Smiley, 107 North Third Street, Delavan.

C. C. Newman, Wittenberg Clinic, Wittenberg.

C. W. Schmidt, 302 Main Street, Watertown.

J. G. Brown, Cambria.

J. A. Szweda, 508 West Street, Beaver Dam.

A. E. Graf, 1023 Russet Street, Racine.

J. T. Murphy, c/o Memorial Hospital, Sturgeon Bay.

G. E. Bryant, Menomonie.

A. C. Halberg, Turtle Lake.

### Changes of Address

D. D. Waters, Madison, to Route 1, Waunakee.

A. E. Talbot, Appleton, to P. O. Box 563, Neenah.

P. D. Anderson, Milwaukee, to 103 17th Place, La Crosse.

P. E. Aszman, Milwaukee, to 3848 South Utopia, Miami, Florida.

W. H. Dohearty, West Allis, to 7236 Milwaukee Avenue, Milwaukee.

J. A. Palese, Milwaukee, to Highland Hospital, South Avenue at Bellevue Drive, Rochester 20, New York.

H. H. Larson, Rice Lake, to Grantsburg.

D. D. Sanders, Long Beach, California, to 960 Shipping Street, Salem, Oregon.

M. E. Sattler, Amarillo, Texas, to 161 West Wisconsin Avenue, Milwaukee.

T. P. Froehlke,* Randolph Air Force Base, Texas, to 2466th Air Force Reserve Combat Training Center, Atterbury Air Force Base, Columbus, Indiana.

R. F. Lamb,* Niagara, to 113 Lyman Drive, San Antonio, Texas.

L. T. Schlenker, Fort Ord, California, to 723 58th Street, Kenosha.

T. A. Gross, Nashville, Tennessee, to 4955 Miles Drive, New Orleans, Louisiana.

J. G. Taylor, Miami, Florida, to 324 East Wisconsin Avenue, Milwaukee.

A. J. Randall, Sarasota, Florida, to 1712 60th Street, Kenosha.

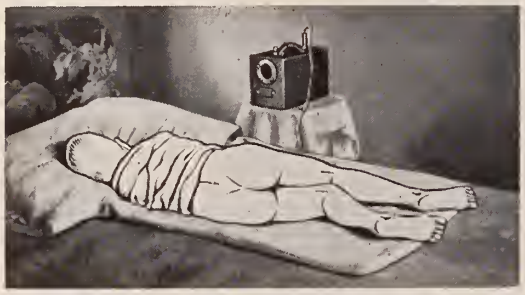
H. B. Christianson, Superior, to 912 Tenth Street, Southeast, Rochester, Minnesota.

## DEATHS

**Dr. Edward Jackson,** 65, a continuous member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association for 37 years, died on December 25 in Milwaukee.

Doctor Jackson was born in Lithuania on May 30, 1888. He was graduated from Loyola University School of Medicine, Chicago, in 1915 and interned at Milwaukee Hospital. He practiced in Milwaukee from then on until his retirement in April of 1953.

Doctor Jackson is survived by his widow, Ann; a brother; and a sister.

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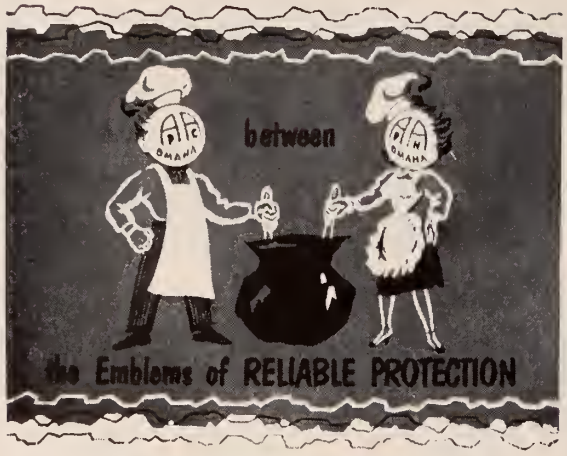


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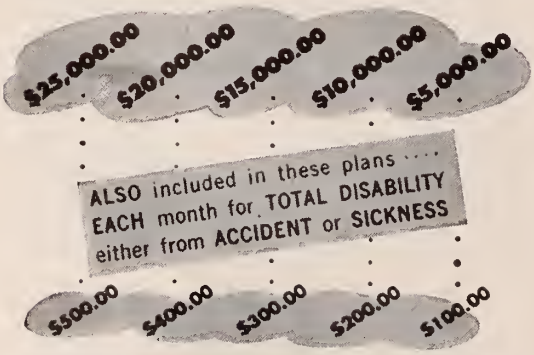


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Dr. Samuel G. Higgins, a widely known Milwaukee eye, ear, nose, and throat specialist died on February 9 at the age of 73.

He had studied in Philadelphia; New York City; London, England; and Vienna, Austria, after being graduated from the University of Illinois College of Medicine in 1905. In 1937 and 1938 he spent six months with a medical missionary team in India and Africa, where he became known as "the cataract man."

He was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association; a Fellow of the American College of Surgeons; and a Diplomate of the American Board of Ophthalmology and the American Board of Otolaryngology. He was a Wisconsin Regent of the International College of Surgeons and a member of the Pan American Congress of Ophthalmology. Doctor Higgins was head of the eye staff at Deaconess Hospital, Milwaukee. In 1946 he was made an honorary member of the Milwaukee Oto-Ophthalmic Society. He was emeritus associate professor of otology at the Marquette University School of Medicine.

He is survived by his widow, Genevieve Coddington Higgins, and a sister, Mrs. Mary Hilgermann of Minneapolis, Minnesota.

Dr. Edward C. Barnes, 89, a Ripon resident for most of his life, died on February 9. Born on February 3, 1865, at Green Lake, he was the son of the late Dr. H. L. Barnes.

He was graduated from Rush Medical College, Chicago, in 1888 and then went to New York, where he took a year's course at the New York College of Physicians and Surgeons. After graduation he remained in Brooklyn for two years and was associated with the Brooklyn City Hospital.

He returned to Ripon in 1890 and set up his practice. He served as a captain in the Spanish-American War; as a major with the 107th Engineers in the 32nd Division during World War I; and as a colonel in the Wisconsin National Guard until his retirement 25 years ago.

Doctor Barnes spent 30 years as a physician at Ripon College. He set up the present college infirmary during the first year of World War II, when army cadets were stationed there.

He was a member of the Fond du Lac County Medical Society, the State Medical Society, and the American Medical Association. He was also a member of the Fifty-Year Club of the State Society.

Surviving are one brother, Dr. Frank Barnes, a dentist at Ripon; one sister, Mrs. Hattie B. Dillon, Ripon; a niece; and a nephew.

Dr. Frederick A. Douglas died on February 18 at his home in La Crosse, where he was an eye, ear, nose, and throat specialist for 36 years. He was born on January 9, 1875, in Lindsay, Ontario, Canada, and was 79 at the time of his death.

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Early in his youth his family moved to Toronto to make its home, and Doctor Douglas was therefore educated in Toronto schools. In 1898 he came to the United States, where he was an instructor in colleges located in North and South Dakota. He returned to Toronto in 1902 and entered Trinity Medical College, graduating in 1906 from Trinity and also from Toronto University.

Moving to North Dakota again, he practiced general medicine there for 7 years. Later in Chicago, doing postgraduate work, he studied diseases of the eye, ear, nose, and throat for a three-month period; and in 1914 he went to Vienna to study. World War I made it necessary for him to leave Vienna after several months' study, and he continued his studies in London and New York. In 1916 he moved to La Crosse and had practiced there until he retired in 1952.

Doctor Douglas was a member of the American Academy of Ophthalmology and Otolaryngology; a Fellow of the American College of Surgeons; a member of the La Crosse County Medical Society, the State Medical Society, and the American Medical Association. He was a past president of the La Crosse County Medical Society, and in 1951 he was one of 30 doctors honored with a life membership in the American College of Surgeons. Doctor Douglas was a member of the staffs of St. Francis, Grandview, and La Crosse Hospitals. He was first-aid chairman for the Red Cross for 12 years.

Surviving are his widow, Lulu; three sisters, Mrs. Ben Nelson of Los Angeles, California; Mrs. F. W. Nourse of Chicago, Illinois; and Mrs. LeRoy C. Cooley, Florida.

**Dr. Arthur L. Breed,** 72, who served the Elmwood, Rock Elm area for 43 years, died on February 20 in Des Moines, Iowa.

Doctor Breed began his practice in Rock Elm in the fall of 1906 after being graduated from Valparaiso University and the Chicago College of Medicine and Surgery. In 1918 he moved to Elmwood and practiced there until his retirement in 1949. Until that time he had been a member of the Pierce–St. Croix County Medical Society, the State Medical Society, and the American Medical Association.

He is survived by his widow, Bessie, and two daughters, Mrs. William Gavin of San Francisco and Mrs. Orvill Nelson of Des Moines.

**Dr. Charles A. Wright,** 78, a retired physician, died on February 21 at Wautoma, where he had lived since his retirement in 1947.

Born on July 29, 1875, in Merton, he had lived in Delavan for more than 50 years. Doctor Wright

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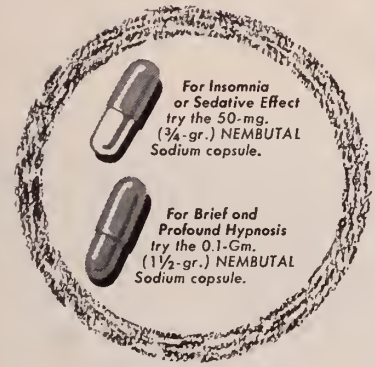


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was graduated from the Hahnemann Medical College of Philadelphia, Pennsylvania, in 1902. Upon his graduation he returned to Delavan, where he practiced for 45 years. In 1935 he became city health officer and held the position until his retirement.

Doctor Wright was a member of the Walworth County Medical Society, the State Medical Society, and the American Medical Association. He became a member of the State Society's Fifty-Year Club in 1952.

He is survived by his widow, Martha; a daughter, Mrs. O. A. Sander, Milwaukee; and a son, Charles, in California.

Dr. Donald R. Searle, Superior physician and surgeon for approximately 40 years, died at Safety Harbor, Florida, on February 21.

Born in Milwaukee in 1885, he was graduated from Marquette University School of Medicine in 1908. He went to Superior in 1912 from Plainfield, where he had begun his practice the year before. He had also studied at the University of Vienna, the New York Polyclinic in 1931, and at Tulane University in New Orleans.

In Superior he was a member of the staff of St. Mary's, St. Francis, and Good Samaritan hospitals and had served as city health commissioner. He had also served on the Wisconsin State Board of Medical Examiners. During World War I he held the rank of captain in the U. S. Army Reserves.

Doctor Searle was a member of the Douglas County Medical Society, the State Medical Society, the American Medical Association, the Wisconsin Surgical Society, and the Interurban Academy of Medicine.

He is survived by his widow, Clara; one son, Lucius H., of Gainesville, Florida; one sister, Mrs. Marie Foley, Milwaukee; and one niece.

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OF THE
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# WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

## National Advertising Program

Beginning in April, Blue Shield and Blue Cross in Wisconsin will get three new salesmen. They are *Life* magazine, *Look*, and *Saturday Evening Post*.

These advertisements in national magazines mark the beginning of the first Blue Shield and Blue Cross nation-wide program of public education. Each Blue Shield ad will be a full page in size and will explain the unique qualities of the program.

Watch for the Blue Shield ads in *Look* magazine of April 20, *Life* magazine of May 3, and *Saturday Evening Post* of May 22. There will be an ad every three weeks in one or the other of the magazines. The Blue Shield messages will appear five times in *Life*, five times in the *Post*, and four times in *Look*. Combined circulation of the three magazines for any one issue is 71,000,000.

The three magazines reach a total of 308,121 households in Wisconsin with each issue. Together, they will reach about 60 per cent of the executive group in Wisconsin—the proprietors of businesses, professional men, and top-level executives. They will also reach about 60 per cent of the white-collar group—salesmen and people in clerical and office jobs. They will reach about 35 per cent of the craftsmen, foremen, machine operators, and nonfarm laborers and about the same percentage of service workers. About 32 per cent of the farmers and farm laborers will also be reached with this circulation.

## Non-Group Coverage

Spring also brings a new look to Wisconsin Physicians Service (Blue Shield) contracts. In May, Wisconsin Physicians Service will offer a new non-group contract which includes maternity coverage for the first time. After May 1, all non-group contracts that are sold in Wisconsin will include surgical, medical, maternity, anesthesia, and x-ray benefits whenever the family contract is purchased. As before, the subscriber may have the choice of "A" or "B" coverage.

The more than 6,000 subscribers who already have Blue Shield non-group coverage under Wisconsin Physicians Service will be offered the opportunity to change their present coverage to include maternity benefits. However, present family WPS subscribers will not be required to include maternity in their non-group benefits if they do not so desire.

The rates for the new non-group contract including maternity on the family program are as follows:

| | *Individual* | *Family* |
|---|---|---|
| Plan "A" | $1.85 monthly | $5.15 monthly |
| Plan "B" | 1.45 monthly | 3.75 monthly |

## Community Enrollment

The second community enrollment experiment in Wisconsin by Wisconsin Physicians Service will be conducted in Monroe County during the week of May 10 to 15. The new non-group contract of Wisconsin Physicians Service will be offered to all the people of the county. At the same time, efforts will be made to enroll as many people as possible in Blue Shield–Blue Cross groups. Both Blue Shield and Blue Cross will be offered to all the people in the county.

Posters and radio and newspaper advertising, prior to and during the campaign, will encourage Monroe County residents to enroll in Blue Shield and Blue Cross at the hospitals or physicians' offices. In addition, every household in the county will receive two mailings which will include literature and the application cards necessary for the individual family to apply for coverage.

The physicians of Monroe County are giving outstanding cooperation in this enrollment program. All 17 physicians in the county are participating physicians in the program.

All persons up to age 70 are eligible to apply for coverage. The enrollment program will stress the full payment feature of Blue Shield and the fact that there is no reduction of benefits under Blue Shield regardless of the person's age. Promotion will also emphasize Blue Shield's policy of not cancelling coverage or raising rates merely because the individual has extensive surgical or medical care.

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# PHYSICIANS' EXCHANGE

**Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.**

FOR RENT: Doctor's office in prosperous paper mill and agricultural community. Centrally located on Main Avenue, Kaukauna, Wis. Reasonable. Write or call A. Gerlach, 5632 W. Auer Avenue, Milwaukee 16.

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WANTED: Doctor to practice in small agricultural and industrial community of 5,500 in southwestern Wisconsin as associate of physician with large general practice. Surgical training preferred. Complete x-ray and laboratory facilities in office. Hospital facilities in town. Address replies to Box 523 in care of the Journal.

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PHYSICIAN–SURGEON WANTED for industrial community serving 3,000 people within a 20-mile area. We will lease attractive doctor's residence and a fully equipped first-aid hospital at a low rental for private practice. Estimated net income of a competent physician is $9,000 to $10,000 for the first year, and his practice should increase each year thereafter. Available for immediate occupancy. Call or write the Goodman Lumber Company, Goodman, Wis.

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PHYSICIANS, with or without public health training, and pediatricians needed in Maternal and Child Health program. Salaries from $6,908 to $9,887. Five-day week, pension, civil service appointment. Write Dr. E. R. Krumbiegel, Milwaukee Health Department, City Hall, Milwaukee, Wisconsin.

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WANTED: A recent military-free graduate to locate in a small community with population under 1,000. Home and office space available. Support and cooperation of all civic groups. Excellent recreational facilities, fine schools, hospital connections available, with excellent opportunity for associating with neighboring medical men. Address replies to Box 541 in care of the Journal.

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WANTED: Associate to general practitioner with active practice grossing well over $50,000. To start on liberal percentage basis, with eventual partnership. No financial investment. New clinic-type building. Hospital staff appointments assured. Write full particulars in first letter. Address replies to Box 542 in care of the Journal.

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FOR SALE by widow of physician: Microscope and McCaskey bookkeeping desk. Write Mrs. R. J. Goggins, Oconto Falls.

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WANTED: As an associate with subsequent partnership arrangement, a young man who is interested in general practice in a community near Madison with excellent hospital and office facilities. Address replies to Box 540 in care of the Journal.

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FOR SALE: Fischer model DSP22 portable shock-proof x-ray unit, with full equipment. Address replies to Box 543 in care of the Journal.

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OFFICE SPACE for rent, to be shared with well-established Madison physician. Completely equipped, x-ray and laboratory facilities available. Address replies to Box 544 in care of the Journal.

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FOR SALE: Office equipment and practice of retiring physician, community of 43,000 population. Address replies to Box 545 in care of the Journal.

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FOR SALE: Office equipment, including portable x-ray and x-ray equipment; instrument sterilizer; new furniture. Address replies to Box 546 in care of the Journal.

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FOR SALE: Small size electric sterilizer, blood pressure apparatus, stethescopes, and many small necessary items used in medical practice by recently deceased physician. Address replies to Mrs. Edward Jackson, 1914 N. Prospect Avenue, Milwaukee. Telephone Br. 2–3910.

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WANTED: Physician for locum tenens work for the month of June, July, or August. Contact H. Y. Fredrick, M. D., Westfield, Wis.

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PRACTICE FOR SALE: Large, well-established general practice for sale by June 1. Six-room office fully equipped. Exceptional income. Easy terms if desired. Owner leaving to specialize. Will introduce. In La Crosse, Wis. Address replies to Box 547 in care of the Journal.

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GENERAL PRACTICE: In town of 1,500 with good hunting and fishing near by. Air-conditioned office. Present physician leaving by end of July, will introduce and help to get started. Contact Dr. A. C. Theiler, Princeton, Wis.

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FOR SALE: X-ray stereoscope, $10; 4 film Cooper-Hewitt viewing lamp, $15; Burdick rhythmic pressure machine with two cuffs, A-1 condition, $45. Write F. C. Christensen, M. D., 209 Eighth Street, Racine, Wis.

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PHYSICIAN AVAILABLE: Completing final year of military service; age 30; family man; one year residency, internal medicine; 3½ years general practice; two years Ob-Gyn in service; member of AAGP. Prefer group. Address replies to Box 548 in care of the Journal.

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## List of Officers and Scheduled Meetings of County Medical Societies

| COUNTY | PRESIDENT | SECRETARY | MEETING DATE |
|---|---|---|---|
| Ashland–Bayfield–Iron | W. J. Tucker<br>Ashland | J. M. Jauquet<br>901 9th Ave., W.<br>Ashland | |
| Barron–Washburn–Sawyer–Burnett | W. F. Vaudreuil<br>Rice Lake | D. F. Hammond<br>Chetek | Second Tuesday<br>7:30 p.m. |
| Brown–Kewaunee–Door | G. B. Merline<br>De Pere | G. M. Shinners<br>409 E. Walnut<br>Green Bay | Second Thursday* |
| Calumet | F. P. Larme<br>New Holstein | J. M. Guthrie<br>Brillion | |
| Chippewa | C. A. Kemper<br>119½ Bridge<br>Chippewa Falls | Paul Murphy<br>Bloomer | Second Tuesday |
| Clark | K. F. Manz<br>Neillsville | J. W. Koch<br>Colby | |
| Columbia–Marquette–Adams | J. P. Harkins<br>Portage | G. B. Ellenz<br>Wisconsin Dells | Every Third Month<br>7:00 p.m. |
| Crawford | R. G. Konicek<br>Prairie du Chien | H. L. Shapiro<br>Prairie du Chien | |
| Dane | S. L. Chase<br>905 University Ave.<br>Madison | G. E. Oosterhous<br>304 W. Washington<br>Madison | Second Tuesday |
| Dodge | Leonard Schrank<br>Waupun | R. F. Boock<br>119½ Front<br>Beaver Dam | Last Thursday* |
| Douglas | C. J. Picard<br>2029 E. Fifth<br>Superior | R. P. Fruehauf<br>1514 Ogden<br>Superior | First Wednesday**<br>Badger Room of the<br>Hotel Superior |
| Eau Claire–Dunn–Pepin | W. G. Cameron<br>131 S. Barstow<br>Eau Claire | G. E. Wahl<br>616 E. Grand<br>Eau Claire | Last Monday |
| Fond du Lac | W. H. Schuler<br>Ripon | H. J. McLane<br>80 Sheboygan St.<br>Fond du Lac | Fourth Thursday* |
| Forest | O. S. Tenley<br>Wabeno | D. V. Moffet<br>Crandon | |
| Grant | E. M. Randall<br>Boscobel | H. W. Carey<br>Lancaster | Last Thursday.<br>March, June,<br>Sept. and Nov. |
| Green | N. E. Bear<br>Monroe | D. E. Mings<br>Monroe Clinic<br>Monroe | |
| Green Lake–Waushara | Russell Pelton<br>Markesan | L. S. Shemanski<br>Wautoma | Last Thursday,<br>every other month<br>starting in Jan. |
| Iowa | C. L. White<br>Mineral Point | H. M. Walker<br>Dodgeville | First Thursday<br>following<br>first Monday |
| Jefferson | O. H. Hanson<br>9 S. Water<br>Fort Atkinson | H. N. Hunsader<br>111 S. Main<br>Fort Atkinson | Third Thursday* |

* Except June, July, and August.
** Except July and August.

## List of Officers and Scheduled Meetings of County Medical Societies—Continued

| COUNTY | PRESIDENT | SECRETARY | MEETING DATE |
|---|---|---|---|
| Juneau | J. S. Hess<br>Mauston | John E. Thompson<br>Mauston | Second Tuesday<br>Hess Clinic in<br>Mauston |
| Kenosha | Richard M. Block<br>520 58th<br>Kenosha | Helen A. Binnie<br>7609 25th<br>Kenosha | First Thursday*<br>Elks Club<br>Kenosha |
| La Crosse | C. F. Midelfort<br>1836 South Ave.<br>La Crosse | Arnold A. Cook<br>1707 Main<br>La Crosse | Third Monday |
| Lafayette | N. A. McGreane<br>128 E. Ann St.<br>Darlington | R. E. Oertley<br>Darlington | Last Tuesday |
| Langlade | D. W. Dailey<br>Elcho | F. H. Garbisch<br>Antigo | Second Wednesday |
| Lincoln | Walter Lewinnek<br>700 E. Third<br>Merrill | J. D. Millenbah<br>Merrill | |
| Manitowoc | W. H. Scherping<br>817 S. Eighth<br>Manitowoc | D. M. Pick<br>926 Eighth<br>Manitowoc | Last Thursday |
| Marathon | H. W. Christensen<br>501½ Third<br>Wausau | J. M. Foerster<br>1024 Steuben<br>Wausau | |
| Marinette–Florence | Kenneth Moss<br>1554 Main<br>Marinette | R. J. Rogers<br>Oconto | Third Wednesday<br>St. Joseph's Hospital |
| Milwaukee | J. G. Garland<br>324 E. Wisconsin<br>Milwaukee | Donald M. Willson<br>324 E. Wisconsin<br>Mr. J. O. Kelley, Ex. Sec.<br>208 E. Wisconsin | Second Thursday |
| Monroe | C. E. Kozarek<br>Tomah | J. S. Mubarak<br>Tomah | Third Monday |
| Oconto | F. E. Zantow<br>Oconto | G. R. Sandgren<br>Suring | |
| Oneida–Vilas | G. R. Thuerer<br>1020 Kabel<br>Rhinelander | Marvin Wright<br>1020 Kabel<br>Rhinelander | Monthly |
| Outagamie | W. A. Adrians<br>103 W. College<br>Appleton | J. E. Gmeiner<br>103 W. College<br>Appleton | Third Thursday*<br>Elks Club<br>6:30 p.m. |
| Pierce–St. Croix | F. B. Klaas<br>East Ellsworth | P. H. Gutzler<br>River Falls | Third Tuesday |
| Polk | H. A. Dasler<br>Cornwall Clinic<br>Amery | L. J. Weller<br>Osceola | Third Thursday<br>7 p.m. |
| Portage | V. A. Benn<br>Rosholt | H. A. Anderson<br>Stevens Point | |
| Price–Taylor | J. L. Rens<br>Phillips | J. J. Leahy<br>Park Falls | Last Saturday,<br>Feb., May, Aug.,<br>and Nov. |
| Racine | G. L. Rothenmaier<br>3115 Washington Ave.<br>Racine | Eugene Pitts<br>420 Seventh<br>Racine | Third Thursday |
| Richland | W. C. Edwards<br>Richland Center | L. M. Pippin<br>Richland Center | First Tuesday<br>Richland Hospital |
| Rock | Milton Davis<br>Milton | H. M. Snodgrass<br>508 W. Milwaukee<br>Janesville | Fourth Tuesday |
| Rusk | L. M. Lundmark<br>Ladysmith | M. L. Whalen<br>Bruce | First Tuesday |
| Sauk | O. V. Pawlisch<br>Reedsburg | J. J. Rouse<br>Reedsburg | Second Tuesday* |
| Shawano | R. C. Cantwell<br>Shawano | A. J. Sebesta<br>Shawano | Third Tuesday |
| Sheboygan | J. F. Kovacic<br>925A N. Eighth<br>Sheboygan | Keith M. Keane<br>1011 N. Eighth<br>Sheboygan | First Thursday |
| Trempealeau–Jackson–Buffalo | O. M. Schneider<br>Blair | E. P. Rohde<br>Galesville | Fourth Tuesday |
| Vernon | L. F. Gulbrandsen<br>Viroqua | DeVerne W. Vig<br>Viroqua | Last Wednesday |
| Walworth | R. A. Moses<br>Delavan | Glen Smiley<br>Delavan | Second Thursday* |
| Washington–Ozaukee | T. D. Elbe<br>Thiensville | F. I. Bush<br>West Bend | Fourth Thursday |
| Waukesha | Peter Theobald<br>Oconomowoc | F. A. Thompson<br>725 American Ave.<br>Waukesha | |
| Waupaca | J. H. Steiner<br>201 N. Main<br>Waupaca | W. R. McInnis<br>Marion | |
| Winnebago | B. S. Greenwood<br>19 Jefferson Ave.<br>Oshkosh | G. B. Hildebrand<br>216½ Main<br>Menasha | First Thursday |
| Wood | H. G. Pomainville<br>Wisconsin Rapids | N. J. Helland<br>Marshfield | Four times a year |

* Except June, July, and August.

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# On the Inheritance of Epilepsy*

By O. P. KIMBALL, M. D.
Cleveland, Ohio

EPILEPSY is defined as "recurrent convulsive seizures." This disease has plagued the human race from time immemorial. In the long history of fact, error, and superstition, there have been three outstanding advances in our knowledge of epilepsy. Hippocrates, with the amazing insight of the genius of his generation, recognized that the seat of convulsive seizures is the brain. The second great advance was made by Jackson,[1] who developed the conception of focal seizures of the cerebral cortex. The third and greatest advance in our understanding of epilepsy is, of course, the result of the recent use of electro-encephalography.

The advance in our knowledge of the genetics of epilepsy has not been so definite, and the literature is still in a rather badly confused state. It is true that Hippocrates regarded epilepsy as hereditary, but the view of heredity in those days was, in general, very similar to the theory of pangenesis. This theory, (Darwin, 1868)[2] stated briefly and in modern terms, gave the view that the *phenotype* determines the *genotype*. According to Darwin, every minute part of the body gave rise to gemmules, which became aggregated in the germ cells and in the next generation gave rise during development to the characteristic in the progeny from which they arose in the parent.

This theory was all changed with the development of experimental embryology in the 1890's and the rediscovery of Mendel's laws in 1900. Clearly, the essentials of the original view of Hippocrates have been given up and are mainly of historic interest; nevertheless, certain implications and remnants seem still to endure.

After 1900, apparently the first extensive study on the genetics of epilepsy, from the Mendelian view, was made by Davenport and Weeks (1911). They point out the defects of the old method where it was considered sufficient to determine with what frequency epilepsy was known to occur among the ancestors or other relatives of an epileptic patient. The frequency was then taken as the index of heredity. This is still the method which is sometimes used. Lennox (1951),[3] for example, finds 3.2 per cent epileptics among the 20,000 near relatives of 4,231 patients. From these data, the frequency is shown to be roughly 1 in 40,[4,5] which is still the figure frequently used by genetic counselors for estimating the probability that an epileptic will have an epileptic child.

Since there is so much confusion in the literature on the relation between heredity and environment in regard to epilepsy, it seems to us not only desirable, but perhaps necessary, to state the main elements in the point of view of our analysis below.

This can be understood best from a description of a family, one which is later included in our tables. One child of this family was in the White Special School for Epilepsy. His mother had seizures all through childhood and adolescence; but by age 17 years, the seizures stopped for no known reason, and she developed into a normal, healthy woman. There were eight living children and only the one having seizures. We arranged for an electro-encephalographic study of this family. The electro-encephalograms of the father and three children were entirely normal. The mother and five children were diagnosed as positive for epilepsy, yet only one child of the five had seizures. The other four had abnormal brain waves with characteristics very similar to those of the mother's, and all four and the mother were diagnosed epilepsy. It is these four children that we would have you remember. I have labelled such cases "Potential Epilepsy," and here-

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after this term will stand for one in whom the genetic potential for epilepsy can be demonstrated but who does not have clinical seizures.

When some changes in the environment of the "Potential Epileptic" occur, frequently clinical seizures start and we have an epileptic. This combination of genetics and environment is responsible for the confusion in our literature and present thinking. There are those who believe all epilepsy is symptomatic or acquired, while others incline to the view that all epilepsy may be hereditary.[6]

That epilepsy is hereditary is shown by the high degree of concordance in monozygotic twins and by the fact that the incidence of epilepsy among the relatives of epileptics decreases as the relationship becomes more distant (Table III, Bridge, 1949).[7] Although such data show that epilepsy is hereditary, yet in order to determine the mode of inheritance and the degree of penetrance, it is necessary to get pedigrees and to make numerical tests of the pooled data. From this point of view, there is no adequate substitute for the analysis of pedigrees.

In any case, the main purpose of the present report is to present the results from an analysis of 520 sibships in which at least one sib is epileptic.

To understand the data and conclusions of this study, it is necessary that we know how the study was made and the source of the cases studied. It is important to know that every history was taken, and the follow-up notes were made by myself through a continuous study for over 20 years. The source of the material is equally important in evaluating the data. For instance, the study of epilepsy in the Detroit schools starts with the epileptic child. It is possible that there are many families with one parent suffering "genetic epilepsy," and at present their children are normal and attending the regular schools; and therefore that family would not be included in these data. While this condition is conceivable, I would minimize the point because it appeared that we became acquainted with most of such families, either because the epileptic parent was a friend or relative of a family coming to the school for epilepsy or because many such families came to the White Special School for Epilepsy for advice because of the popularity of the school and are included in the data from the school.

The study of epilepsy in Cleveland was started during the school year of 1930–31 as a part of a survey of all the children in the special schools. This survey was made to determine more accurately the diagnosis of these special cases and to learn the cause of the high absenteeism connected with these schools. It was soon learned that in many cases the absence was due to seizures. During that school year 450 children were excluded from school because of seizures. By arrangement with the school physician, those who were not already under medical supervision were referred to me for diagnosis and treatment. Thus began a study of epilepsy which soon included adults as well as children.

In June of 1934, a school clinic was organized in the Department of Special Education of the Detroit Public Schools.[8] The purpose was to make a complete study of 419 children who were unable to attend the regular school because of epilepsy. These were the actual known cases, but it was thought that this was approximately the total number of children of school age with epilepsy. It was soon learned, however, that many children whose seizures occurred at night or early in the morning were going to the regular schools without revealing the fact of their seizures. Also, an equal number were going to parochial schools. Within a few months, the importance of further care and special schoolwork was obvious to Miss Alice Metzner, head of Special Education; to Dr. Burt Shurly, President of the Board of Education of Detroit; and to myself. By January, 1935, a school for children with seizures was ready. The White Special School of Detroit was the first school of its kind in the country, and the fact that a public school was open for children with epilepsy made it possible and easy for parents whose child had been suspected of having seizures to bring him to this special school for diagnosis and schooling, if needed.

Before this school opened, I found what every student of epilepsy has encountered when attempting to get the family history: there was either an ignorance of the family history or an unwillingness to admit any inherited tendency. In such cases only patience and repeated attempts to complete the history, even over a period of 2 or 3 years, will eventually produce an accurate diagnosis. As soon as this complex disease was considered a school problem and a special school was

ready to accept their child, transport him to and from school, care for him when sick, give him a good lunch, provide adequate educational facilities, and give medical treatment if this was desired, there was a marked change in the attitude of the parents.

In the White Special School the parents appeared anxious to bring out all the facts about the child's disease and gave the family history in detail, if it was known. In this full-time day school, close relationship was established between the parents and the school personnel. The parents were invited to an open house once each semester; and the physician, nurse, and principal devoted half of one clinic day to teaching the parents what they should know about epilepsy. They were given an understanding of the nature of the disease, its rational care in the home, and the purposes of this special school.

In the White Special School for Epilepsy, children may go from kindergarten through high school. There is an enthusiastic and cooperative Parent–Teacher Association, which encourages the parents to make regular progress reports and discuss any phase of epilepsy with the teachers as well as the nurse and the physician. In a school of this type, it is natural that many family histories which would contribute authentic information on the genetics of epilepsy would be studied. Frequently when parents did not know one or both branches of the family, they would write to some member of the family in Italy, Poland, or Scotland, for example, or to an older member of the family in this country, in order to complete the family history accurately.

The data reported in this study were obtained from families studied in the White Special School for Epilepsy in Detroit and cases studied, with the same purpose and interest, in my private practice in Cleveland during the years 1930–1951. As stated above, we have gone to great length to establish an accurate history, and we diagnosed no one as "genetic epilepsy" unless the family history warranted that diagnosis. Because of this attempt at authenticity, a comparatively small number of families are taken from the whole number of cases studied. And in these data, the term "epilepsy" means genetic epilepsy.

For a graphic picture of genetic epilepsy, the family of J. J., one of our children, is given.

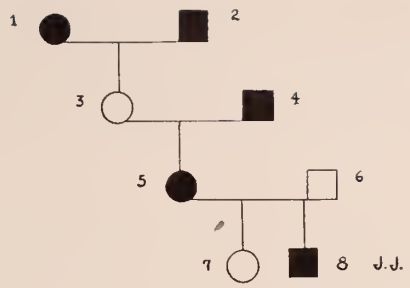


Fig. 1

The information for this pedigree chart was given by the mother (No. 5). She was of average intelligence and presented no evidence of degeneration. She knew her grandparents (Nos. 1 and 2) very well. She states that they both were epileptics and that there were cases of epilepsy among the ascendants of each for generations. Also, her grandmother (No. 1) had severe migraine, and this was characteristic of her ascendants. Her mother (No. 3) was an only child and was not an epileptic but did have severe migraine. Her father (No. 4) was an epileptic and stated that there were several known epileptics in his lineage. The mother, (No. 5) an only child, had had nocturnal seizures from childhood and migraine since she could remember. The father (No. 6) was not an epileptic, and no history of epilepsy was found in his lineage. The sister (No. 7) was younger than the patient and had not had seizures.

A summary of eight years' data was published in 1942,[8] showing the frequency of association of epilepsy with feeblemindedness, migraine, chorea, and insanity. The present report deals primarily with the genetics of epilepsy and should help to answer the question, "Should young adults with epilepsy plan to have children?" This is a very old problem; and answers in the past have too often been based on personal opinion and prejudices.

The history on each side is known in less than half of the families. Therefore, the diagnosis of genetic epilepsy will be less than half the number of epileptics studied. The families selected for genetic study must show an accurate diagnosis. Consequently, only 190 families of genetic epilepsy were chosen from more than 3,300 children studied in the White Special School of Detroit and 104 families from the 583 adults and children

studied in Cleveland. In these families, either the mother or father was known to have genetic epilepsy. In the total of 294 families, there is a total of 1,070 children, and among these children there are 399 who have seizures.

TABLE 1—*One Parent an Epileptic*

| Source of data | Number of Families | Number of Children | Number of Epileptics | Per cent of Epileptics |
|---|---|---|---|---|
| Detroit | 190 | 708 | 258 | 36.4 |
| Cleveland | 104 | 362 | 141 | 39.0 |
| Totals | 294 | 1,070 | 399 | 37.3 |

The data in Table 2 are of families where the parents were clinically free of epilepsy. To his knowledge, neither parent ever had convulsions; but there is a definite history of epilepsy in the family of one parent. The important fact brought out in this table is that the offending parent, although clinically not an epileptic, carries the genetic factor the same as if he were an epileptic. To prove the presence of this genetic factor in an apparently normal parent, electro-encephalographic studies were made in five families. In four of the five cases studied, the suspected parent was diagnosed an epileptic by the electro-encephalogram.

TABLE 2—*Neither Parent an Epileptic, but Epilepsy in Their Families*

| Source of data | Number of Families | Number of Children | Number of Epileptics | Per cent of Epileptics |
|---|---|---|---|---|
| Detroit | 124 | 488 | 155 | 31.8 |
| Cleveland | 98 | 284 | 119 | 41.9 |
| Totals | 222 | 772 | 274 | 35.5 |

The data of Table 3 pertains to four families, not included in Tables 1 or 2, in which both parents are epileptic. In these four families, there are 25 children; and 20 of these, or 80 per cent, are epileptic.

The view that epilepsy is a simple autosomal recessive prevailed for many years and is still frequently mentioned (Penfield and Erickson, 1941, p. 405).[9] After the discovery that in many instances when neither parent of an epileptic was epileptic, yet one parent showed cerebral dysrythmia diagnostic of epilepsy, it was held by some that epilepsy was a dominant, since the one parent was heterozygous for the hereditary factor responsible for the disease. In the present series there are 222 sibships, with a total of 772 sibs and 274 affected, with 440.65 expected. This gives a penetrance of 64 per cent, which is approximately the same as the penetrance in the 294 sibships where one parent is an epileptic.

The above data correspond closely with the result of studies of epilepsy in monozygotic twins. In 1951, Gedda[10] published a table on twins with epilepsy; and the same year we have a report by Lennox, "The Inheritance of Epilepsy as Shown by Monozygotic Twins." Adding the data of these studies, we find that there are 79 concordant and 56 discordant sets of monozygotic twins in regard to epilepsy, or 58 per cent concordance and 42 per cent discordance for the entire 135 sets of twins. This means that of the 270 individuals with genetic constitution for epilepsy, 214 showed the trait, which is equal to a penetrance of 79 per cent; and the standard error is $\pm 2.5$ per cent. This is significantly higher than the average of 64 per cent penetrance for the sibs shown in these data. However, this is what one should naturally expect, since in addition to the causes of lack of penetrance in monozygotic twins, ordinary sibs are subject to the genetic modifiers in which they may differ from one another. Indeed the difference between 64 per cent and 79 per cent may possibly be taken as a measure of these genetic modifiers in producing the lack of penetrance.

After a careful genetic study, with corrections for small families, the above data show that epilepsy, in all probability, is an autosomal dominant with about 65 per cent penetrance.

TABLE 3—*Both Parents Epileptic*

| Number of Families | Number of Children | Number of Epileptics | Per cent of Epileptics |
|---|---|---|---|
| 4 | 25 | 20 | 80 |

During this study we encountered families whose epilepsy had certain characteristics which had been passed down from one generation to the next with great exactness—for example, the family in Table 3, with both parents epileptic and a family of 16 children—each parent insisted that there had never been an adult epileptic in his lineage, but stated frankly that childhood epilepsy had occurred frequently for many genera-

tions. The convulsive seizures were usually severe, and quite a few deaths had been caused by convulsions; but the children always "outgrew" the epilepsy as soon as they passed puberty. By 1951, half of this family of 16 had grown up and passed puberty; and in each case, as soon as the rapid growth and development of puberty started, the seizures stopped and the individuals grew into robust, healthy, normal adults.

Another family whose genealogy was known since 1630 was found. On this family record, statements are found attesting to the fact of the occurrence of epilepsy in almost every generation of the family and at the same time showing that there had never been a case of epilepsy in childhood or early life but that the convulsions always started at middle life, usually in the early forties. The women thought that their epilepsy was due to menopause change. My patient of this special brand of epilepsy was a man, 42 years old when he started having hard nocturnal convulsions. He had been a teacher of physical education, in excellent health all his life, and at 42 was principal of a large school in Detroit. We could find no cause for convulsions, other than the hereditary factor which had occurred in every generation at about 40 years of age for three hundred years.

In the first family one is inclined to think of a hereditary factor or gene which exerts its influence on the brain all through childhood but is entirely cancelled out by growth, development, and glandular function after puberty.

In the second family, the gene must have had some qualifying characteristic which prevented it from exerting its influence on the brain until some of the changes of senescence had taken place. At least the patient I knew had symptoms suggestive of early senescence, for by age 50 he appeared to be 70.

Now we come to the important issue: What should we do about epilepsy? Epilepsy has been with us for ages, it has been a part of each civilization. A few physicians have made heroic efforts to conquer this problem; but, individually and alone, they are almost as pathetic in their efforts as the Roman citizen with sticks and stones trying to knock the devil out of a convulsing human in the street. In the aggregate, some progress has been made; and physicians, as in other fields, have been able to improve, relieve, and lessen the anxiety and agony in many a home; but the disease, "epilepsy," is with us today. Epilepsy can not be legislated away, nor can it be ignored. The present trend toward normalizing epilepsy, when the physician advises epileptics to lead a normal life, raise a family, drive cars, and forget about their illness, is the most fallacious kind of teaching yet devised. Such teaching promotes false security, disappointment, and frequently disaster.

At present, 19 of the 48 states still require a statement about epilepsy for marriage licenses. Ohio has such a law; and, although epileptics are marrying just the same as others, if there should be any question regarding their marriage, they stand in the uncomfortable position of having falsified to the state.

Such laws are not good laws; they do not prevent trouble, they only punish an individual for making a false statement. It is the physicians and teachers who will eventually conquer this disease and not the lawyers and law makers. When the physicians of this state come to grips with this problem and act in accordance with their science, they can, and I think they will, create an "Institute of Human Biology" to learn all the pertinent facts about diseases such as epilepsy, feeblemindedness, and constitutional diseases and then to teach every citizen of the state the simple truths about them. That alone would outweigh all the laws that can be devised to punish us. Two such institutions are organized and thriving in the neighboring states of Michigan and Minnesota. The first Hereditary Clinic was founded at Ann Arbor under the leadership of Dr. Lee R. Dice in 1940, and the Dight Institute of the University of Minnesota was founded in 1941 and is now under the direction of Sheldon C. Reed. These are the first and best known of eight such institutions in the United States.

What will be the answer when an intelligent, young epileptic seeks your advice on marriage and children for him? There is no common answer; every one is an individual problem. Naturally, the first step is an accurate and complete diagnosis. If the final diagnosis is brain injury with convulsions, then there is no reason for worry over heredity; and no advice pertaining to genetic epilepsy is warranted. However, if the

diagnosis is genetic epilepsy, he should be told, with all kindness and sincerity, that his disease could be, and probably would be, passed on to his children. In fact, more than one third of children of epileptics are themselves affected. And even if his children were not so afflicted, his grandchildren might be. In the end, the individual must make the decision, and he should have the simple truth on which to base his decision.

12337 Cedar Road.

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A SYMPOSIUM ON CLINICAL MEDICINE

Sponsored by Wisconsin Academy of General Practice and The Wisconsin Valley Chapter of W.A.G.P.

*(Arranged by Educational Services of Lederle Laboratories)*

Wausau Club, Wausau, Wisconsin, Friday, June 25, 1954

10:00 A. M. to 6:30 P. M.

PANEL OF SPEAKERS

"The Non-Surgical Treatment of Thyroid Diseases"—James Cook, M. D., Division of Endocrinology, Cleveland Clinic, Cleveland, Ohio.

"The Diagnosis and Treatment of Brucellosis"—Wesley W. Spink, M. D., Professor of Medicine, University of Minnesota, Minneapolis, Minnesota.

"Significant Factors in Management of Arthritis"—D. Murray Angevine, M. D., Professor of Pathology, University of Wisconsin.

"Pediatric Emergencies of the Newborn"—John Reichert, M. D., Assistant Professor of Pediatrics, Northwestern University, Chicago, Illinois.

"Immunological Aspects of Poliomyelitis"—Clifford G. Grulee, Jr., M. D., Director of Graduate Medicine, Tulane University. School of Medicine, New Orleans, Louisiana.

"The Treatment of Hypertension and Evaluation of the Newer Drugs"—Pending.

"Clinical Experiences and Recommendations on the Use of the Newer Antibiotic Agents"—Mark H. Lepper, M. D., Clinical Associate Professor of Medicine, University of Illinois, Chicago, Illinois.

The clinical session begins at 10:00 A. M. and continues until 12:20 P. M., at which time physicians attending will be joined by their wives for a luncheon. The luncheon speaker will be William B. Hildebrand, M. D., Menasha, Wisconsin, President of the American Academy of General Practice. The clinical session will resume at 2:00 P. M. and continue until 5:30 P. M. A cocktail party for physicians and their wives from 5:30 to 6:30 P. M. will conclude the program.

All physicians, and especially general practitioners from Wisconsin, the Peninsula of Michigan, and northern Minnesota, are invited. No Registration Fee—Six Hours Formal Credit to A.A.G.P. members.

For hotel, motel and resort information, write Arthur W. Hoessel, M. D., Housing Chairman, 115 McIndoe Street, Wausau, Wisconsin.

# The Harvey Hospital

By W. S. MIDDLETON, M. D
Madison

PART 2 (CONCLUSION)

WHILE the movement for the provision of hospital facilities for Federal soldiers in the North was being pressed most actively, disquieting accounts of sanitary conditions in northern camps were appearing in the public press. *The Weekly Patriot* (January 31, 1863) published Senator Frost's report for the Joint Select Committee on conditions at Camp Randall to the Wisconsin Senate on Friday, January 23, 1863. In this document there appeared this damaging evidence:

"The darkest scene in this dark picture is presented by the places used for hospital purposes. Noble looking young men, who had left comfortable homes to defend our liberties, are stretched upon a filthy floor, and in some cases nothing to shield them from its hard surface except a blanket or a little damp straw. It is a humiliating fact that these dens called hospitals have not the comforts of the pest-houses of our larger cities. We are pained to say that these places are uncleanly, uncomfortable, unhealthy, and a disgrace to our State.

"We recommend the passage of a bill appropriating five hundred dollars for hospital purposes, subject to the disbursement of a commissioner, to be appointed by the Governor."

When the *Wisconsin State Journal* attempted to mollify the public resentment by a moderate statement, a reader wrote a scathing criticism (January 28, 1863):

"The first building that I entered was a wooden building on the outside of the camp grounds. The lower floor was occupied by convalescents, who had accommodations such as we would desire for our sons and brothers. But of these I have nothing to say. The upper floor was divided into two rooms, filled with very sick men with various diseases, mumps, inflammation of the lungs, pleurisy, fevers of different kinds. In their beds were dirty sacks filled with straw, used over and over again, till it is nearly powdered. I say filled, but so scantily that the men were scarcely lifted from the floor upon which their sacks rested, there being no semblance of bedsteads, except one rough affair knocked together from boards by a compassionate comrade, and one cot. The result is that those occupying the sacks actually suffer from the cold. The filth in these rooms was terrible. These men, too sick to rise up, and suffering from diseased lungs, two of them evidently near death with consumption, are obliged to expectorate upon the floor, and even upon their bedding."

In a forthright statement, Surgeon Gage, commander of the post hospital at Camp Randall, met these complaints. His courage and candor served to restore some measure of confidence; but the shortcomings in supplies and equipment were not easily relieved.

"Madison, January 29, 1863

Editors State Journal:

As much has lately been said about Camp Randall and the hospitals of the 25th, etc: I beg permission to occupy a small piece in your columns, for the purpose of stating some of those things *which have not been told*, and which in my judgment have not received their proper share of attention; which have been omitted (though I presume not designedly) by the various reports, official and unofficial, which from time to time appeared in your paper. I beg to state then, that *we have applied, in the proper manner*, for those things needed to make the sick of our regiment comfortable, and that many of the most important and essential necessities applied for have never been received, and not the slightest attention given to our urgent demands. We have asked for ample room to accommodate fifty to seventy-five patients. We have asked for straw with which to fill our bed-sacks. We have asked for bunks upon which to place our sick. Had we not, upon our own responsibility, taken possession of unoccupied buildings, the large majority of our sick would have had *no place* to shelter them from the piercing cold, or the pitiless storm—they might have been, nearly to the present time, totally uncared for. We have been furnished with *only wet straw* to fill our bed-sacks. We have had supplied five or six rickety bunks, (enough of such would have been a God-send to us, and for which we would have been deeply grateful), upon which to place from fifty to sixty persons.

"Now, sir, for the want of a proper and sufficient supply of bunks, we have been compelled to place our patients upon the floor, and they have thus been so thickly crowded that it has been constantly a difficult matter, even, to get about among them; and as rapidly as one patient was so far convalesced, as to admit of his being sent back to quarters, another, seriously ill, *must take his place*, and thus it has been from day to day, and constantly.

"We admit that a proper degree of cleanliness and order has not existed, (and which we, too, have profoundly regretted), but we at the same time most emphatically assert, that, under the circumstances, it has been impossible for us to make it otherwise. Give us the needed amount of room, and the bunks upon which to place our patients—in a word, give us the few things we have asked for, but which have been denied—we will guarantee

that order will come out of confusion, and comfort out of discomfort.

"In reply to the article signed, ***, containing the *fling* at the 'regimental surgeons', believing the writer anxious only to befriend the sick soldier, I will only say that there has been a sufficient quantity and good quality of food for the sick in these hospitals. It is not often proper, or desirable, that patients should eat what they want, or that those, unacquainted with the operation and progress of disease and its treatment, would be pleased to have them. If * * * is truly desirous of benefiting the sick soldier, he had better leave *these things* to the discretion and direction of the 'regimental surgeons.'

"Allow me to say a word or two, also, in relation to the barracks occupied by the regiment. They certainly are badly constructed, and uncomfortable enough. They are built, too, upon the very lowest ground in the Camp, and where all the impurities and filth of the Camp is at once carried, by the flowing water of the frequent rains and thaws which have been so common during the last thirty days. Only a day or two since, a perfect flood of water was pouring from the whole camp directly upon that portion of ground occupied by these buildings; and I believe it next to impossible to keep it in a decent and healthful condition during the continuance of such weather as has been prevalent for the past few weeks.

Respectfully, Your obedient servant,
M. R. Gage,
*Surgeon*"

*The Weekly Patriot* published a vitriolic blast under the caption: "The Soldiers Again" (February 7, 1863). Its reporter had visited Camp Randall. The officers interviewed said that some elements of the ration were "outrageously bad." The account continued:

"If the editor of the Journal believes it not, let him put his olfactories to the test—let him spend a night in one of those contracted bunks, on wet straw, with one coarse blanket for a covering—inhaling the heated air from sheet iron stoves that require a regular 'fireman' to beat back the cold from the unbattened walls that separate that 'hole of Calcutta' from the biting air without—let him inhale the odoriferous effluvia that arises from the old stench of excrements left there by former occupants—let him drink in the commingled expirations of an hundred lungs—let him crowd two in a 3½ feet bunk, and two bunks deep at that, with low ceilings and poor ventilation, and then see if he would not endure paroxisms of the nightmare so intolerable as to dream of the 'horrors of the middle passage.'

"We should judge these barracks to be about 14 x 40 feet with a petition (*sic*) in the centre. This gives a passage way on either side of about 3½ feet-width of bunks 3½ feet—one above the other—something after the order of old canal boats, with no comforts of cleanliness possible, fit for man. The laws of health forbid these closely packed and filthy stalls to man's occupation. No wonder that so many fatal cases occur. No wonder that sickness riots in our camps. No wonder that soldiers lose their 'heart and ambition.' And then, look at the cooking stalls. Little 7 x 9 ricks with no convenience—no floors—dirt and filth run in wanton riot. When it rains scarcely anything can prevent a deluge from above, and what does not come in by that 'route,' finds an easy access by the surface flood, so that cooks and waiters stand in mud, like hogs before a barnyard trough. The soldiers take their food through a small open space, and bolt it in the open elements, or use their savory beds for tables, for there is not room enough within these huts to eat their food, without it be upon their uninviting pallets."

Nor was the sanitary state of Madison above reproach if one may judge by a later communication (*Wisconsin State Journal*, July 8, 1864):

"Streets—We wish to call the attention especially of the Mayor, Common Council, Street Commissioner, and Chief of Police, to the disgustingly filthy condition of Main and Pinckney Streets bordering the Park. The piles of manure lying loose around, the accumulation of the last six months, rotting and festering in the hot sun, is a disgrace to the city authorities of the Capital city. If left longer in its present condition it will breed a pestilence in our midst. If those whose duty it is to attend to this glaring nuisance fail to remove the evil, we recommend the businessmen of the city to take the matter in hand and clean out the city stable."

In all troop concentrations, communicable diseases constitute a recurring and constant hazard. Vaccination against smallpox was not general in the period of the Civil War. Hence, the panic that the following news item excited (*Wisconsin State Journal*, December 9, 1863) can be envisioned:

"Small Pox at Camp Randall—We regret to learn that several cases of smallpox have appeared at Camp Randall. A hospital for their reception is being prepared in the rear of the camp. It is of course most likely that many of the soldiers have been exposed to contagion, and it would be well for our citizens generally to take the precaution of being vaccinated, since if the disease prevails to any extent in camp, it will be difficult to prevent its communication to persons in the city."

The facilities for the reception of Confederate prisoners at Camp Randall had been under fire. Furthermore, the hospital quarters had proved inadequate from the outset. As early as April 11, 1862, the *Wisconsin Daily State Journal* reported: "The Sick from Camp Randall—Two members of the 16th and three of the 17th were to be removed this afternoon to the building on Gibson Street, used as a hospital by the 15th regiment." On January 10, 1863, the *Daily Patriot* announced the construction of a new hospital at Camp Randall under the supervision of Mr. Van Slyke. Its dimensions were

to be 280 feet long by 12 feet high, with two wings each 80 feet long. The *State Journal* for February 21, 1863, gave the following reassuring report:

"The main hospital building is 440 feet in length, including two wings. The main part and the wings are each 22 feet in width. Each wing forms a ward, and the main part of the building is divided into two wards. There are now about 150 bunks placed in their proper position in the hospital, and there is sufficient room to acommodate 50 more. The walls of the entire structure are substantially built of inch boards placed upright, and battened both inside and out. Ample arrangements for ventilation are made in the roof. Each ward is heated by two large stoves, the pipes of which are extended overhead the entire length of the room, and the temperature kept up is very equable and agreeable. The kitchen arrangements are ample, and seem to be particularly well adapted to the ends sought."

In submitting the quarterly report for the period ending March 31, 1863 (*Wisconsin Daily State Journal,* April 23, 1863), Post Surgeon Otis Hoyt wrote forcefully:

"I venture to say that no private practitioner of medicine and surgery can show a better record in this State, if in the United States. Our success arises mainly from the fact that the patients are constantly under the supervision of one of the surgeons at the post, so that the remedies are timely administered and effects noted, and diet properly regulated, without any interference from well-meaning friends and neighbors, which the private practitioner is constantly meeting with, frequently thwarting his best and most scientific endeavors."

Then follows the official report:

"To Gen. W. A. Hammond, Surgeon General, U. S. Army:

"The following is respectfully submitted as to the sanitary condition of this post for the quarter ending March 31st, 1863:

"1. No change as to location of camp has been made since last report.

"2. The weather has been unusually variable during the three months ending this quarter.

"3. Measles, Diphtheria, Pneumonia, Bronchial Inflammation and Mumps have prevailed to a great extent throughout this State, and in some instances as many as eighty persons out of a thousand have died of these diseases, in this vicinity.

"4. The occupation of the troops has been such as is usual in camps of instruction and in garrisons.

"5. The troops are in new and comfortable quarters with good roof ventilation. The space in cubic feet for each soldier is about three hundred and fifty.

"6. The personal clothing of the men is of good quality and ample in quantity, with the exception of blankets, which will not average more than three and a half pounds each.

"7. The rations are abundant in quantity, and the bread and coffee is much better in quality than during the previous quarter, and in fact very good.

"8. Limestone water in abundance is procured by sinking wells from twenty-five to thirty feet.

"9. Since last report, a pavilion has been constructed for hospital purposes, of sufficient capacity to accommodate 180 beds, and giving 1,200 cubic feet of space for each bed, with good roof ventilation. Two cisterns have been constructed in the hospital yard, which will hold about 400 barrels of water each, and will afford a fair supply of soft water for hospital use, as soon as the spring rains fill them.

Camp Randall, March 31st, 1863.

OTIS HOYT,
*30th Reg. W. V. I. Post Surgeon*"

The *State Journal* (September 18, 1863) recorded the visit of Lieutenant Colonel J. Wilson, Medical Inspector, United States Army, to survey various buildings for the location of the United States Convalescent Hospital. Among other sites, the Water Cure and the residence of former Governor Farwell received especial attention. The latter appeared to be favored. The note continued: "The class of patients that will be sent to this hospital will not be those suffering from acute diseases, but mainly convalescents and such wounded men as can be transported from the army North. There will therefore be none of the objections to its establishment in the city which might be felt if it were to be an ordinary hospital. It will, if taken, doubtless be fitted up in the best style, and rendered in appearance one of the most pleasant and cheerful places in the city." This position contrasted strongly with the doubts and reservations expressed by the *Patriot* (September 22, 1863): "We see it stated that ex-Governor Farwell's octagon house, in the 3rd Ward, is to be used as a hospital for soldiers. The bare mention of such a thing has created quite an excitement in the 3rd Ward, for the idea of bringing soldiers or any others infected with all sorts of disease right into the heart of the city is enough to create the wildest apprehensions. We do hope that Mr. Marshall will not allow that building to be used for any such purpose. It would spoil the sale of it for any other purpose."

Appropriately, official word of the authorization of the new hospital came to its most energetic proponent:

"Washington, September 27, 1863

"To Mrs. Gov. Harvey:

"I have ordered the establishment of a hospital at the Farwell House in Madison, to be called the Harvey Hospital in memory of your late lamented husband, the patriotic Governor of Wisconsin, who

lost his life while caring for the wounded soldiers of the State.

EDWIN M. STANTON"

Former Governor Leonard J. Farwell had begun the construction of this mansion in 1854. Its cost was $45,000. Octagonal in form, its walls were solidly built of limestone; and the lofty ceilings of its three stories offered a sound nucleus for the proposed hospital. Certain remodeling was initiated, and additions were soon planned. Apparently, faulty control of the admittances led to certain hardships. Active objection to the transfer of obviously debilitated soldiers was recurrently voiced in the local press. However, the *Daily Patriot* for December 21, 1863, reported:

"Harvey Hospital—Workmen are today engaged in laying the foundation of one extensive wing, running south-west from the main building 300 feet. The addition will add materially to the capacity of the hospital, and afford room for many invalids now waiting to be transferred to it."

The progress on the additions did not satisfy the citizens of Madison, although by January 11, 1864, the framing of the second story was complete. This achievement is particularly noteworthy in the light of the severity of the winter. The thermometer registered 40 degrees below zero on the first two days of the year. Inadequate fuel was available to protect the soldiers at Camp Randall. One hundred and thirty of them suffered from cold injury in their barracks, and many were removed to hotels in the city for temporary cover.

On Thanksgiving Day (November 26, 1863) the people of Madison served dinner to 150 convalescing soldiers and a few guests in the new hall of the hospital. This hall was seventy feet long. A chorus of fourteen young women from the Third Ward furnished musical entertainment. The reporter (*Daily Patriot*) erroneously ascribed full credit to brewer Rodermund for the supply of lager beer but the following day (November 28, 1863) divided the credit with "those other wholesouled brewers, Mr. Breckheimer and Mr. Hausman." The staff was feted by the citizens of Madison in a complimentary dinner for Surgeon F. L. Town at the American House, December 19, 1863, on the occassion of his transfer to Louisville. Among the toasts was one to "the medical faculty of Madison" by Doctor Favill of the Harvey Hospital.

In general, the residents of Madison soon came to take commendable interest and pride in the good works of the Harvey Hospital. Dr. Howard Culbertson was deemed an able administrator, and Doctors Favill and Brown splendid clinicians. The command and personnel of this institution reciprocated in kind. The *State Journal* (December 17, 1863) reported the situation thus: "The Harvey Hospital—This has become one of the creditable institutions of the city, and all about it, externally and internally, is neat and orderly. The patients, trained to the bearing and conduct of soldiers, are distinguished by their civility and quietness in the streets and elsewhere, and the fears of those who thought the vicinity of the hospital would abound with noise and confusion are proved unfounded. We discover that U. S. Quartermaster Van Slyke, of this city, is gratefully regarded by the officers of the hospital for the obliging facilities he has afforded them in perfecting their arrangements and fixtures."

On October 21, 1864, the barn on the property of George Hyer in the Third Ward (which property was then tenanted by James Sumner) burned to the ground. A mare, buggy, cutter, 200 bushels of oats, and a buffalo robe were destroyed, at a total loss of $800. The barn was valued at $400, with insurance of $100. The *State Journal* remarked: "The boys at Harvey Hospital turned out in force, and it was owing mainly to their exertions that the house and some of the adjoining property was not consumed."

On December 30, 1863, the rolls of the Harvey Hospital recorded 214 convalescent soldiers. The following effusive letter to the *Wisconsin State Journal* (January 4, 1864) indicates that they were well remembered by the citizens of Madison and the staff of the hospital on New Year's Day:

"U. S. Harvey General Hospital
Madison, Wis., January 2, 1864

"Editors State Journal:

We had a superb dinner yesterday, furnished by our considerate steward, with the co-operation of the patriotic ladies of Madison. Yes, it was a *capital* dinner, and it did both body and soul good. It makes us feel happy to realize that we have friends at home, it makes us more patriotic, and as we receive favor after favor from the generous women of the Capital, each of us inwardly determines that he will fight better, when returned to the field, to defend a Government under which reside

so many noble, whole-souled women. Yes, we pledge ourselves, gentlewomen, that we will strike and strike nobly in the defense of our righteous cause, and when the Angel of Hope conceals her bright face from our view—when doubt and fear hang like a dead weight upon our souls, we will think of those we left at home, and the recollections of them will rouse our hearts to deeds of noble daring. We will *fight* for you because we *love* you. Do not think your efforts are all lost, because some selfish and cynical old granny tells you we are incapable of appreciating kindness. Your labors are not lost; each manifestation of regard for us strikes a tender chord in our breasts, awakening *love, hope, confidence, and patriotism;* it speaks in tender accents to the heart; it makes us better soldiers. Could 'King Jeff' have gazed in upon our table yesterday, and witnessed the 'stuffed turkeys,' pies, and cakes, prepared for us by the 'Women of the North,' he would have retired, his confidence in secession shaken. 'Why?', do you ask? Because he would realize that the soldiery was not deserted by the 'people at home'—that Union sentiments were not upon the wane; sustained by such noble women at home, he would realize the fact that the North could not be broken up; with such attention, such encouragement, he would think that 'the Yankees *would* fight.' But we have said enough—more than we at first intended—and thanking you and our wide-awake Steward, who does not forget us, we will say—adieu.

Truly yours,
SOLDIERS OF HARVEY HOSPITAL"

The new wing of the Harvey Hospital was opened on February 23, 1864, with appropriate exercises. Surgeon Culbertson, in greeting the assemblage, paid due homage to Mrs. Harvey for her zeal and persistence in winning the contest for northern hospitals. Music and military tableaux completed the entertainment. The reporter (*Wisconsin State Journal,* February 25, 1864) concluded: "The hall is as snug and neat as a choice design, wood and plaster as white as snow, and has full and convenient ventilating arrangements. The ward hall below is very commodious, and seems to possess every required advantage." The press of the day carried cards of thanks for recurring gifts of food and supplies to the patients of the Harvey Hospital.

The rapport between the civilian population and the Harvey Hospital was not always felicitous. On January 19, 1864, the *Daily Patriot* observed: "The residents in the vicinity of the Harvey Hospital were awakened this morning by the breaking of the revellie (*sic*), which we understand is to be hereafter one of the regular orders of that institution."

The administrative officers of the hospital found it necessary to control the food sources from overzealous friends and kinfolk of the patients. The *Daily Patriot* (March 18, 1864) published the following communication:

"U. S. Harvey General Hospital
Madison, Wisconsin, March 17, 1864

"Editor Patriot:

Persons donating delicacies to the sick, inmates of this hospital, are respectfully requested to leave such articles with Mrs. Linda Hunt, nurse, in charge of the preparation of the extra diet of the hospital. Such articles will be issued to the patients, by her, on the order of the physicians in charge of the several wards. Those intended for a particular patient should be sent in the same manner, with the name of the patient for whom intended attached; and if, in the opinion of the physician treating the case, it would be proper for the patient to use it, it will be given to him;—otherwise, the party who forwarded it will be notified of the fact, and the articles will be subject to his or her order.

SURGEON U. S. V.,
*in charge*"

While minor friction might be anticipated by the location of a military hospital in a civilian area, much more serious implications would accrue from such charges as were incorporated in an article in the *Patriot*, May 30, 1864:

"The injunction 'honor the brave,' does not seem to be observed at the Harvey Hospital. We are informed that they have a very summary way of disposing of the remains of soldiers who die in that institution. The undertaker is sent for, and the body given in his charge; he (the undertaker) places it in a pine coffin, *dumps* it into his wagon, and conveys it to the burial place, without any ceremony or guard. Sometimes two or more bodies are thus consigned to their last resting place 'uncared for, and unmourned.' Such treatment to all that remains of a gallant soldier is simply disgraceful. The commonest soldier, according to the articles of war, is entitled to a guard to officiate at his burial, and certainly our volunteers should not be deprived of this last token of honor."

Disgraces to the uniform were relatively infrequent. Yet evidences of license in violence at the hands of soldiers were not lacking in that period. In the *Wisconsin State Journal* (December 15, 1863) there appeared the following item: "Atrocious Outrage—Last night, about 6 o'clock, as Mr. G. G. Cody, an industrious resident of the First Ward, was passing a saloon in that ward, known as the 'Beehive', kept by a Mrs. Bernhard, three men in soldiers' uniform rushed out, and after striking him to the ground by a blow on his left eye, robbed him of a piece of cloth he was carrying, worth $27.50. Deputy McDougal and Chief Shealy are looking after the perpetrators of this outrage, and the officers at the camp are also on the

alert. From what we hear of the management of this saloon, its license should be at once revoked."

Several further acts of violence on the streets in which soldiers were involved seriously prejudiced their reputation in Madison. In a street brawl early in June, James Fisher soundly trounced three "blue coats" who abused his dog. Taking exception to certain political views of a group of prominent Madison lawyers in front of the Capitol House, some soldiers from Camp Randall set upon Judge Vilas. When Judge Bush interceded, they chased him up the street. On August 8, a Negro soldier was reported to have drawn a revolver on a civilian. On August 27 (1864) the *Patriot* recounted the uncalled-for attack of a group of soldiers upon Assistant Secretary of State Spencer near the Union House. When he eluded them in his carriage, they pursued him into the country. Overtaking him on the Van Wie farm, they assaulted the farmer, took Spencer's horse and carriage, and returned to Madison. In an editorial, the *Patriot* trenchantly remarked: "Such outrages by crowds of drunken soldiers have become an every day occurrence; and if there is a remedy it should be applied. We hold the officers in command directly responsible for these lawless acts; if they cannot keep their men under subjection, it is high time they were removed, and competent men put in their places. As it is, citizens should arm and be prepared to defend themselves from these brutal attacks of the rowdies in blue, who at present are quartered in the city."

Isaac Beecher of Cottage Grove died as a result of a stab wound of the neck incurred in a brawl between soldiers and civilians in Doerschlag's saloon on King Street, August 1, 1864. The *Wisconsin State Journal's* account (August 2) sounded a reasonable admonition:

"The affair is a most terrible one, and has been preceded by other affrays within the last few days, which have resulted in bloodshed, but not loss of life, and there is a loud call for something to be done to prevent such outbreaks and lawless proceedings in the future. We think that by proper concert between the civil and military authorities something might be done. If there were less low doggeries about town where men get crazed with strychnine whisky, we should have far less crime to record.

"That some soldiers disgrace themselves and their uniform by riotous proceedings is no reason for the general denunciations of the soldiery, which we regretted to hear in some quarters last night. In the affair which had so tragic an end last night both parties appear to have been to blame, and liquor seems to have been at the bottom of it."

Apparently the military discipline at Camp Randall was indeed at a low ebb, for on September 13, 1864, the solders rioted and demolished the sutler's booth. One soldier sustained a fatal wound of the thigh, and property damages amounting to almost $1,000 were incurred. The *Wisconsin State Journal* (June 4, 1864) noted: "Served Him Right—A drunken soldier took occasion to insult a respectable woman in front of the Post Office an evening or two ago, when Hugh Lewis, of the Invalid Corps, who lost one arm in the glorious old Second Regiment at Gainesville, sailed in with the other and gave the fellow a dressing that he will not soon forget. The pluck and spirit of the gallant veteran was warmly admired."

Meanwhile, the political contest for the presidency was being waged with unprecedented vigor. Abraham Lincoln was seeking a second term on the Republican ticket. Major General George B. McClellan, deposed from high command, was his Democratic opponent. A favored device of that period was the unofficial poll of various groups of soldiers. The *State Journal* reported the overwhelming support of President Lincoln in the straw vote of soldiers in the Harvey Hospital. The *Daily Patriot* retorted in characteristic vein (September 16, 1864):

"A wag tells us the manner in which the above vote was taken: The first soldier accosted was very sick, nigh unto death, and it was with great effort he answered the question:

'For whom do you vote, Abraham Lincoln or George B. McClellan, the traitor?'

'Abraham Lincoln.'

"The second soldier to whom the same question was propounded was in much better health and was slowly recovering. He boldly answered:

'George B. McClellan.'

'Deprive this man of his brandy!' was the order given in a loud tone of voice.

"The third soldier accosted was a large, robust and strong man, who had wrestled with death and entirely vanquished him.

'I vote for George B. McClellan!' said he.

*'Send this man to the front!'*

"Of course such orders as these had the desired effect, and but few votes were hereafter given to 'Little Mac.' "

The good Democratic women of Madison lent fuel to the flames by giving a silver fruit knife to each of the fifteen sick and wounded soldiers of Ward E who had signified a preference for McClellan; the *Daily Patriot* (October 6, 1864) reacted violently:

"Soldiers! are you going to vote for the man who robs you of the fruit of victory by making the emancipation of Negroes the object of the war? Remember Andersonville, with its 35,000 of your companions in arms suffering the untold horrors of the most loathsome imprisonment, and who might be free but for the obstinate unfeeling favoritism of Abraham Lincoln? Can you, when you remember these facts, vote for him? The man who votes for Lincoln endorses the latter's power to arrest any citizen and keep him in prison just as long as he (Lincoln) pleases."

In the same issue, the *Patriot* published the following letter:

"Harvey Hospital, Madison, Wisconsin
October 3, 1864

"Editors of Patriot:

In Saturday's issue of the Journal, I see they make the statement that one of the fifteen Democratic soldiers who had received a fruit knife from the ladies of Madison had thrown it into the stove and renounced McClellan:—It is a *lie*, a malicious *lie*. One of their 'noble' Union defenders took it out of his pocket and threatened to throw it into the stove; but he was politely informed that if he had done so, we would prefer charges against him. Thinking discretion the better part of valor, he returned it. The Journal need not trouble its head about the Fifteen, for we are not to be scared or bought.

Yours for 'Little Mac,'
ONE OF THE FIFTEEN"

In the heat of the contest, political lines were being ever more closely drawn. When a group of the staff of the Harvey Hospital indicated a virtual boycott of tradesmen of Democratic persuasion, the scorn of the *Patriot* was limited only by the range of its invective (October 10, 1864):

"Some half a dozen men in Harvey Hospital, whose combined salaries amount to probably $1,000 a year, and hence, whose expenditures are limited to that amount, have resolved to bestow (*sic*) their patronage on loyal hucksters only, thus depriving the copperhead candy and fruit dealers of these immense profits derived from their lavish expenditures of money. Shut up shop Democrats, your 'occupation's gone.' " From its particular notice of Steward Cyrus A. Burke, it may be assumed that the *Patriot* considered him the leader. The next day the paper pressed the attack further:

"The *patriots* of the Harvey Hospital are in a fair way to have a time of it. They propose not to trade with or give THEIR PATRONAGE to anybody but abolitionists, and, as all the hucksters in Madison are Democrats, they will have to confine themselves to a Grahamite diet, and even in the matter of food imitate one of their illustrious leaders, the virtuous Horace Greeley. How are you off for meat? Bully boys!!"

Taking up the gauntlet, one of the convalescent soldiers at the Harvey Hospital wrote to the *Wisconsin State Journal* (October 11, 1864) that the resolution embodied only the design to patronize the tradesmen of known loyalty. No mention of disloyalty was contained in the declaration. He continued:

"So far as able bodied men are concerned, we ask those who have had the care of sick men, whether it requires able bodied men to attend the duties of nurse, or whether invalids should be called upon for this duty?

"Our characters are written upon the battlefields of our country, we fear not a contrast with the characters of the men who threaten to *expose us!* God knows they will never venture near a battlefield to obtain facts! May a just God mete out to these men such punishment as revilers of our country and its supporters deserve; is the prayer of,

Yours, for no party, but for Our Country
K"

A further item in the same issue of the *Wisconsin State Journal* bears witness to the sharp issues between the rival newspapers. "The *Patriot* has a great deal of trouble with the veterans of Harvey Hospital. It has an article in regard to them in its last evening's issue in which occur such choice phrases as the following, applied to men who have risked their lives in defense of the country, and have been scarred, and many of them maimed for life, in that glorious service: 'Ignorant tools,' 'acting out lying precepts,' 'blockheads,' 'these fellows,' 'disgracing the uniform they wear,' 'willing to do the *dirty work* of their *masters*,' etc.

"The 'ignorant tools' make a pretty sharp reply in another column. 'Ignorant' as they are, they are too much for the 'logy Editor' of the *Patriot*."

On October 20, 1864, the *Patriot* published "The Loyal List." In a community of 10,000, only 50 individuals in business or the professions were so categorized. Among this limited group were 11 lawyers, 2 (of 15) physicians, and 1 billiard hall keeper. Decrying the "contemptible scheme," the *Patriot* proceeded to indicate that there were no "loyal" meat market or saloon keepers.

On October 22 the Union mass meeting was staged. Five hundred teams joined in the procession, which was illuminated by myriads of torchlights. Various political and patriotic organizations turned out in number. One of the banners was inscribed: "Har-

vey Hospital Lincoln and Johnson Club—405 Union voters—no party but our country—death to traitors North or South." The episode of the gifts to the soldiers supporting McClellan was thus recalled: "58 Union men in Ward E—How are you, Little Mac-Kernels with your fruit knives?" "All Hail, Hoosiers, Buckeyes, and Quakers; Our Peace Commissioners, Grant, Sherman, Sheridan, Farragut; How are you 'fighting General' on a 'peace platform?' Don't you feel like Dodding? We 'Grant' the 'Little Macs' an 'Early' 'Phil' of Sheridan's pills."

Within a year from the establishment of the Harvey Hospital, additional facilities were developed by the War Department in Prairie du Chien and Milwaukee. The latter hospital was largely devoted to the care of officers. References to the branch of the Harvey Hospital at Camp Randall indicate a division of functions. A total census of 600 patients was reported on January 17, 1865. W. Y. Selleck, military agent for Wisconsin, writing to Governor James T. Lewis from Washington, cited a new ruling of the Surgeon General of the United States Army that authorized a transfer of all wounded and disabled soldiers unfit for duty for 60 days. (*Wisconsin State Journal*, February 7, 1865). Obviously this decision contributed to the load of convalescent soldiers and may have determined the inclusion of certain elements of the post hospital at Camp Randall under the control of the Harvey Hospital. At one time (May 16, 1865) Assistant Surgeon George A. Calkins, in charge of the Camp Randall branch, reported 200 patients on his rolls. Immediately upon the cessation of hostilities came the clamor for separation from the military service. The Harvey Hospital experienced a temporary increase in the demand for convalescent care; but shortly the call of home and the assurance of stability brought a sharp reduction of bed occupancy.

Meanwhile, the plight of Union prisoners of war paroled from Confederate commands was attracting increasing attention. Mrs. Harvey wrote:

"Vicksburg, Miss., April 16, 1865

"Hon. J. T. Lewis, Madison, Wis.:

"Dear Sir: Enclosed I send you a complete report of all the names of Wisconsin soldiers who have died at Andersonville, Ga., giving the number of grave, date of death, and disease. Also the names of those now in paroled camp near this city. Could you hear them relate the horrors through which they have passed, you would wonder that a man was left to tell the tale. Many are entirely broken in health and spirit, but generally they are improving rapidly.

"The Sanitary Commissions, through their agents, have scattered northern bounty, and never was it more needed. They go from tent to tent, from man to man, and give him all he needs. Large quantities of vegetables, potatoes, onions, and sauerkraut are daily distributed. Every delicacy for the sick is found in the hospital. Oh, how we love to do for them, they have suffered so much.

"They were all anxious to get pen, ink, and paper. Among the thousands we find no man unable to write, except some from Tennessee. This contrast between Northern and Southern soldiers is very striking.

"When our men were paroled, a rebel officer was stationed to write their names, while they 'made their mark.' As one after another came up and wrote their own names, the officer said, 'Why, d—n it, can they all write?' I wonder if he thought this had anything to do with our intelligent patriotism and final success.

"Volumes could be filled with thrilling incidents as related by those who were eye witnesses, but I have not heart to report them, or time to write them.

"Say to the friends that everything that is needed for the comfort of these prisoners has been and is being sent by the U. S. and Western Commission. I have all that I can do, and all the goods that I can distribute.

"I do hope our people will take an interest in the great Northwestern Fair, coming off in Chicago in May. This will finish up our work nobly.

"Two hospital boats are now at the wharf to take the sick North.

Yours respectfully,
C. A. P. Harvey
*State Agent*"

The *Wisconsin State Journal*, May 29, 1865, published the following significant item: "Closing up Harvey Hospital—In accordance with a General Order for vacating all hospitals rented by the Government as speedily as possible, the Harvey Hospital building is being vacated. The transference of the inmates to the General Hospital at Camp Randall began today." Yet the routine reports disclosed continuing activity. A news note of July 6, 1865, reported the movement of 185 patients from St. Louis to the Harvey Hospital on the 2nd. Much later, (September 9, 1865), Chaplain Bandli of Harvey Hospital disclosed the receipt of orders from Washington to abandon all United States general hospitals in Wisconsin. This provision left only the post hospitals at Camp Randall and Camp Washburn for the reception of the sick and disabled. Notice of the sale of bed linen, pillows, mattresses (hair and shuck) and towels from the Harvey Hospital (September 29) appeared in the *Wisconsin State Journal* (September 27). The

blankets and counterpanes had brought good prices. "All this property is in a clean, wholesome condition."

Mrs. Harvey was not unaware of a further tragic by-product of the war, as attested by the following (*Wisconsin State Journal*, July 15, 1865): "The visit of Mrs. Harvey to this city, already noticed, was in relation to an enterprise which must enlist the cordial sympathy and cooperation of all humane and patriotic citizens of the state. Having for three years past devoted herself to the alleviation of the sufferings of our soldiers in Southern hospitals, proving an angel of mercy to many a sick or wounded soldier of the State, when help and consolation seemed most remote, she is now turning her attention to providing a support and education for the orphaned children whose fathers died in the service of the country."

When the need for a military hospital no longer existed, Mrs. Harvey proposed the utilization of the Harvey Hospital as "The Soldiers' Orphans' Home." Although this function was actually initiated by the reception of 84 orphans on January 1, 1866, the transfer from the Federal to the State control occurred on the official payment of $10,000 for the property by Wisconsin on March 31, 1866. With the termination of this building's function as the Harvey United States Government Hospital, our immediate objective ends. As is true of so many incidents of war, its short but useful span was closed very quickly. While the subsequent functions and fortunes of the Farwell mansion encompass other enterprises important in the history of Wisconsin, only one arrests our present attention. Under the Reconstruction Act of 1866, when the Soldiers' Orphans' Home had discharged its mission in 1875, the mansion was transferred to the Regents of the University of Wisconsin for the establishment of a medical college or courses of lectures in all branches normally taught in such institutions, when in their judgment such college should be required by the medical profession of the State. President John Bascom, of the University of Wisconsin, in his report of 1875, declared: "The time does not seem to have arrived for the establishment of a medical department. The profession of the State are not agreed as to the desirability of a medical college in its bounds, and comparatively few earnestly support such an institution. Such a college, if established, should

Fig. 4—The Harvey Hospital (after its transfer to the Soldiers' Orphans' Home).

certainly be located at Milwaukee, as affording, by its size, far more clinical advantages than Madison, or than any other place within the State. We should be glad to unite a medical college in Milwaukee to the University and should hope both to aid it and receive aid from it." An act of the Legislature (1876) authorized the Regents to sell the property or to use it for any expedient purpose. It was purchased for the Norwegian Theological Seminary and College. So passed the Farwell mansion from governmental ownership and functions. The building was finally burned in the 80's.

In 1908 an invitation was extended to all students in the public schools of Madison to contribute up to five cents each for a memorial marker for the Harvey Hospital. Any shortage in the contributions of the children was guaranteed by their elders. The dedicatory exercises were interrupted by threatening weather and completed in the Pilgrim's Congregational Church on Friday, May 29, 1908. Attorney General Gilbert made the

presentation address, in which he effectively expanded the theme of the youth of the Union soldiery. Indeed, in his analysis, they were the actual saviours of the Republic. Mayor J. C. Schubert accepted the marker on behalf of the city of Madison. Erected at Spaight and Brearly Streets, its inscription reads: "On this city block, during the Civil War, stood Harvey Hospital, and later the Wisconsin Soldiers' Orphans' Home, both established through the influence of Mrs. Harvey, whose honored husband, Governor L. P. Harvey, had accidentally been drowned in the Tennessee River, at Pittsburg Landing, Tenn. near the Shiloh battlefield, April 19, 1862, where he had gone after the battle, with supplies for the comfort of the sick and wounded Wisconsin soldiers."

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1300 University Avenue.

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## ANESTHESIA AND ANALGESIA

Physicians attending births can provide valuable information by carefully recording anesthetics and analgesics that were used under Item 29 on the latest birth and fetal-death certificates. This data is being collected and tabulated at the request of the State Medical Society's Division on Maternal and Child Welfare, which is currently undertaking special studies on maternal and fetal-neonatal deaths.

One of the problems encountered has been the reporting of such non-specific items as "General," "Gas," "Routine," "Ob," or just a "√" or "X." Even worse is no entry at all—which could mean the type of anesthetic and analgesic was not indicated or that none was used.

Information gleaned from birth certificates in the past has been valuable to all practicing physicians in Wisconsin. It has broadened knowledge of problems and helped to direct effort toward improved care which has reduced maternal and infant deaths. To be of real value, information collected must be meaningful. We therefore urge all physicians attendant at deliveries to help by entering the *specific* anesthetic and analgesic or "None" if none was used.—ROBERT PURTELL, M. D., *Chairman, Division on Maternal and Child Welfare.*

## CHICAGO MEDICAL SOCIETY PLAN FOR TRANSPORTATION TO SAN FRANCISCO A.M.A. CONVENTION AND HAWAIIAN TOUR

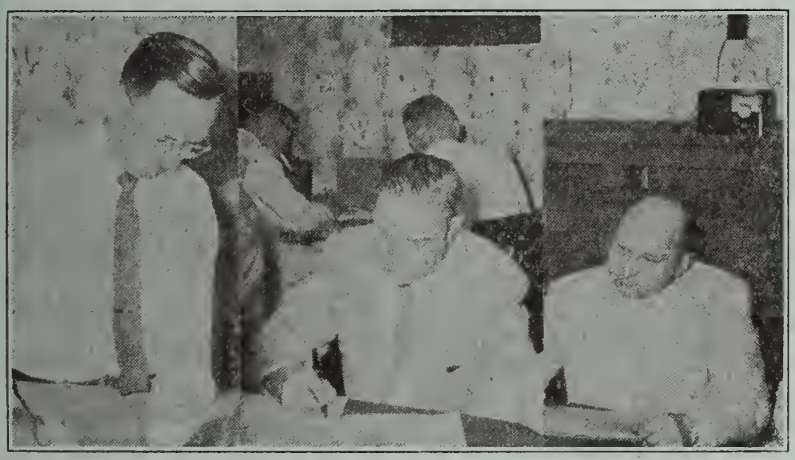
The Transportation Committee of the Chicago Medical Society announces a special all air transportation plan to the A. M. A. Convention at San Francisco and a tour of the Hawaiian Islands following.

Take off from Chicago is scheduled for noon on Sunday, June 20, with arrival in San Francisco the same day. Take off for Hawaii will be at midnight on June 25 from San Francisco. The return flight from Honolulu—following a tour of the Islands by air and limousine—is scheduled for midnight, July 4. Return to Chicago will be on July 5.

A few reservations are still available. Those interested may contact Elmer V. McCarthy, M.D., Transportation Chairman, Chicago Medical Society, 86 East Randolph Street, Chicago 1, Illinois.

# THE MEDICAL FORUM

# WISCONSIN DELEGATION MEETS WASHINGTON OFFICIALS



**BIDS FOR THE CONSTRUCTION of the proposed new State Medical Society building were opened at a meeting at the present medical society building in Madison April 14. Pictured, left to right, are Architect Allen Strang, Madison; Dr. N. A. Hill, Madison, and Dr. E. M. Dessloch, Prairie du Chien. The two doctors are members of the State Medical Society's building committee.**

## CONSTRUCTION TO START ON SMS OFFICE BUILDING

Madison, May 5.—The go ahead for construction of the new State Medical Society building on the south shore of Lake Monona in Madison has been authorized by the trustees and officers of the SMS Realty Corporation.

The officers of the Corporation also serve as trustees. They are Drs. E. M. Dessloch, Prairie du Chien, president; H. Kent Tenney, Madison, vice president; N. A. Hill, Madison, treasurer; and Mr. C. H. Crownhart, Madison, secretary.

The action to start construction was taken upon the recommendation of the councilors and officers of the State Medical Society who also serve as members of the SMS Realty Corporation.

Construction is expected to begin almost immediately with clearing and leveling operations. Total cost of the building is estimated at about $350,000. The new office is scheduled for completion in April, 1955.

## All Marinette Doctors Give to Foundation For Medical Education

Madison, April 28.—Every member of the Marinette–Florence County Medical Society contributed $25 to the American Medical Education Foundation recently.

The contribution is not made a part of county society dues, but is voted in a lump sum each year, and is donated in the name of the Marinette–Florence County Society. The sum is determined on the basis of so much per member.

Members of this society are Drs. J. M. Bell, Clark H. Boren, Clarence H. Boren, John W. Boren, Jr., James A. Boren, Guy R. Duer, Charles E. Koepp, James V. May, Philip R. McCanna, Kenneth J. Moss, Alexander T. Nadeau, Kenneth G. Pinegar, Henry F. Schroeder and James D. Zeratsky, all of Marinette; Leonard H. Graner, Coleman; Henry W. Haasl, Peshtigo; Ralph B. Pelkey, Pound; Raymond J. Rogers, Oconto; Richard J. Maginn, Ray F. Lamb, and Edward A. McCormack, Niagara.

## Urge HEW to Visit State for Close Look At Insurance Plans

Madison, May 3.—High Washington officials took time out recently to hear what five Wisconsin physicians had to say on pressing health matters, including pending legislation.

Drs. A. J. McCarey, Green Bay, president-elect; S. E. Gavin, Fond du Lac; J. M. Bell, Marinette; W. A. Fischer, Frederic, and J. A. Enright, Milwaukee, spent three days on Capitol Hill visiting congressmen, department heads and others who play significant roles in the nation's health affairs. They represented the State Medical Society at the Wisconsin Congressional dinner meeting of the U. S. Chamber of Commerce.

### Perkins Invited

They asked Roswell B. Perkins, assistant secretary of the Department of Health, Education and Welfare, to visit Wisconsin personally for a first-hand account of progress and problems in the health insurance field. He was advised of the rapid growth of Blue Shield and the Wisconsin Plan, the experiment with insurance for the "near-indigent" in Price–Taylor counties, and the availability of reinsurance through local sources for the proposed catastrophic coverage plan of Wisconsin Physicians Service.

Mr. Perkins is the leading spokesman for the Administration's reinsurance proposal in Congress. The government contends that reinsurance is not available from private, voluntary sources and that government funds are needed to encourage experimentation in many fields of insurance coverage.

In a visit with the Rt. Rev. Msgr. Donald A. McGowan, director of the bureau of health and hospitals of the National Catholic Welfare Association, the Wisconsin delegation urged a "look before you leap" policy with respect to

*(Continued on page 293)*

# NEW AUXILIARY IN ONEIDA-VILAS COUNTIES IS 33RD

Madison, April 1.—With the formation of the Woman's Auxiliary to the Oneida-Vilas County Medical Society late in March, the number of auxiliaries has reached 33.

At the organizational meeting, Mrs. W. S. Bump, Rhinelander, was chosen president. President-elect is Mrs. R. W. Schmitt, Phelps; secretary is Mrs. V. W. Komasinski, Rhinelander; and treasurer is Mrs. E. C. Eickhoff, Land O' Lakes.

Guests who attended this initial meeting were Mrs. C. R. Pearson, Baraboo, president, and Mrs. V. S. Falk, Edgerton, president-elect of the state auxiliary; Mrs. C. E. Zellmer, Antigo; Mrs. L. J. Bayer and Mrs. K. A. Morris, Merrill.

### Fifteen Members

The new auxiliary starts with fifteen paid-up members. They are Mesdames W. F. Gager, T. M. Haug, John Magner, R. R. Osborne, C. A. Richards, Irving Schiek, Jr., W. K. Simmons, G. R. Thuerer and Marvin Wright, all of Rhinelander; J. J. Colgan, Eagle River; and J. P. Sprague, Minocqua, besides the officers.

Though their projects are not yet organized, they expect to follow the pattern of the Woman's Auxiliary to the State Medical Society, which means that they will work for the recruitment of nurses, promote the sales and distribution of "Today's Health," solicit funds for the American Medical Education Foundation and the Student Loan Fund of the state society, cooperate with community endeavors in mental health and civil defense, and do everything they can to further the public relations of the medical profession.

### Chairmen Chosen

Another recently organized auxiliary—the Eau Claire-Dunn-Pepin group—elected charter officers last November. They are Mrs. S. B. Russell, Eau Claire, president; Mrs. G. D. McAffee, Eau Claire, president-elect; Mrs. R. J. Bryant, Durand, secretary; and Mrs. A. A. Lorenz, Eau Claire, treasurer.

Project and committee chairman who have been elected include the following: Mrs. R. A. Buckley, American Medical Education Foundation; Mrs. H. M. Aitken, archives and historian; Mrs. C. H. Falstad, civil defense; Mrs. Graham Cameron, finance; Mrs. K. L. German legislation;

Mrs. W. T. Mautz, mental health; Mrs. Ralph Frank, nurse recruitment; Mrs. E. L. Mason, program and public relations; Mrs. H. C. Huston, publicity; and Mrs. R. L. Kennedy, Today's Health and Bulletin.

**OFFICERS OF THE NEWEST AUXILIARY were snapped at their organizational meeting late in March. In front, left to right, Mrs. E. C. Eickhoff, Land O' Lakes, Teasurer; Mrs. W. S. Bump, Rhinelander, president; and Mrs. R. W. Schmitt, Phelps, president-elect of the Woman's Auxiliary to the Oneida Vilas County Medical Society. In back, left to right, Mrs. C. R. Pearson, Baraboo, president, and Mrs. V. S. Falk, Edgerton, president-elect of the state auxiliary.**

# *ILLINOIS MEDICAL SOCIETY PREPARES PR OUTLINE FOR COUNTY SOCIETIES*

Madison, May 12.—The small town MD who sets out to develop a public relations program within his society often is staggered by the dozens of suggested public relations projects contained in the deluge of material he may receive from various sources.

To help county medical societies, the Illinois State Medical has prepared a 26-page booklet entitled "The Public Relations of County Medical Societies: Outline of a Program."

The booklet is distributed to all Illinois county medical society secretaries and serves as a sort of "rule and guide and ready reference source book of ideas."

The book outlines past medical public relations efforts in response to national need and defines public relations. It summarzies the role of the Medical Society and its individual members as well as that of the Auxiliary. The operation of a public relations committee is outlined.

Several chapters are devoted to handling public relations complaints and suggesting cheap techniques for eliminating them. They also consider the doctor in relation to his community, voluntary health insurance, politics, organized labor and socialized medicine. One chapter deals with ways of publicizing public relations projects and letting the world know what doctors are doing.

A copy of this public relations handbook may be obtained from the State Medical Society of Wisconsin without charge.

# DRAFT CALLS ON PHYSICIANS TO BE RESUMED JULY 1

Madison, April 21.—The Department of Defense expects to reactivate its calls for physicians through selective service starting July 1.

The first call for Wisconsin physicians in several months will be issued in July. Selective service expects that all hospital interns and residents obligated for military service will have to be called to active duty during the fiscal year beginning July 1. There is a backlog of 1953 medical school graduates and a small number left over from Priorities I and II. This may mean that selective service calls will not be particularly heavy during the last half of 1954.

### Will Call Reserves

At the same time, the army has announced that it will draw on its medical corps reserve rolls for activation of some 276 physicians starting in July. This figure is expected to satisfy replacements needed until October. Most of the call-up will be filled from Priority I and II reserves.

The Defense Department urges hospitals to make short-term arrangements with physicians completing their internships or residencies on July 1. This will assure these physicians "of a means of livelihood and the opportunity to continue their education, as well as to contribute to the needs of the hospitals" while awaiting orders the last six months of 1954 and the first six months of 1955.

### Should Get Commissions

After July 1, 1955, all physicians with military service obligations are urged to get commissions during their internships. Doing so will remove them from the jurisdiction of their draft board and will allow the Defense Department to request delay in the call-up of men for whom the department has recommended additional training. The department expects to announce a program whereby a certain percentage of interns will be allowed to continue into residencies.

A recent poll of medical school deans has revealed the following preferences among present day students:

1. The army is preferred by 27 percent, the navy by 37 percent, and the air force by 36 percent.

2. Thirty-nine percent of medical students prefer service immediately following internship, 15 percent would rather have it after two years of hospital training, and 46 percent would rather wait until they complete full residency training.

## Dr. Martin's Inaugural As AMA President Will Be Broadcast June 22

Chicago, April 16.—The inaugural address of Dr. Walter B. Martin, Norfolk, Va., president-elect of the American Medical Association, will be broadcast directly from the ballroom of the Palace Hotel in San Francisco the evening of June 22. The program will be telecast locally.

The annual meeting of the AMA, at which Dr. Martin will be inaugurated, takes place June 21 to 25.

A number of Wisconsin MD's and several staff members of the state society are planning to attend.

## La Crosse Worker for Fluoridation Is Fined For Not Registering

La Crosse, April 15.—One of the leaders of a "Joint Committee of Physicians and Citizens" to support fluoridation of the La Crosse city water supply was fined $25 for failing to register the committe with the county clerk as a political group.

The committee engaged in extensive publicity and promotion in connection with an April 6 referendum on whether the fluoridation program in La Crosse was to be continued.

The State Corrupt Practices Act requires that any association, organization, committee, club or group which endorses or opposes any measure to be voted on by the people must file with the county clerk before making any expenditures or receiving any contributions for carrying on its work.

Statements of contributors and expenditures must be filed on the second Saturday preceding any election and final statement must be filed within three weeks after such election. Likewise, any campaign literature circulated by a club or individual must disclose the author and the candidate or name of the organization in whose behalf the literature is being circulated.

In the La Crosse case, the fine of $25 was the minimum penalty under the statutes.

The complaint against the pro-fluoridation group was brought by a chiropractor who was the leader of the opposition movement.

In the La Crosse referendum, the city voters decided to get rid of the equipment which had been used to fluoridate the water supply.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The only way you can be deprived of the time you need is in case of death or a long term disability.

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Milwaukee 3, Wis.

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# AMA TRUSTEES TESTIFY AT HOUSE COMMITTEE HEARINGS

## Self-Employed Do Not Want Social Security, Blasingame Says

Washington, April 6.—To explain the opposition of the American Medical Association to compulsory coverage of physicians by social security, and to the "waiver of premiums" provision of the same bill, Dr. F. J. L. Blasingame, Wharton, Texas, addressed the House Committee on Ways and Means. Dr. Blasingame is a member of the AMA Board of Trustees.

Dr. Blasingame stated that the AMA is firmly opposed to compulsory social security coverage for the self employed, though it does not oppose individual physicians coming under social security on a voluntary basis.

### Plan Own Retirement

**"I am here to assure you gentlemen that the members of the medical profession do not feel discriminated against by having been excluded from the provisions of . . . the Social Security Act," Dr. Blasingame told the committee. "On the contrary, we believe that we are capable of planning for our security in old age and are not desirous of governmental intervention.**

"Another very practical consideration is the fact that only a small proportion of the self-employed physicians consider age 65 as a line of demarcation between their working years and retirement. Those who are able to work prefer to keep right on taking care of sick people. Many of them taper off the amount of work they do as they grow older. However, in an unpublished study prepared by our Bureau of Medical Economic Research, it was found that one half of the physicians actually retiring from practice after age 65 did so after age 74.

### Do Not Fit Pattern

". . . Old age benefits under the Act simply do not fit the economic pattern of the life of the self-employed physician. To compel him to come under the provisions of this portion of the Social Security Act would represent a failure to understand that physicians, like many other professional people, serve the citizens of their community best by following their traditional economic pattern of life. . .

**"The American Medical Association has repeatedly expressed its support of the Jenkins–Keogh bills which are now before this committee for consideration . . . I believe all members of this committee understand that these bills would provide only tax deferment, not tax avoidance. It would give the 11,000,000 self-employed people who want to save for their old age an opportunity to do so under conditions approximately equal to those provided by corporate pension plans approved by the Bureau of Internal Revenue . . .**

### Oppose Waiver

"The second portion of the bill concerning which I would like to comment . . . proposes a waiver of premiums and the preservation of insurance rights of individuals with extended total disability . . . We are constrained to oppose this portion of the bill because it most definitely would become an entering wedge for the regimentation of the medical profession by creating the mechanism for the adoption of a federal cash permanent and total disability benefit program, which in turn could lead to a full fledged system of compulsory sickness insurance.

### Changes Penalize

"It is true that under the present system, a man who is permanently or totally disabled or who goes from covered to noncovered employment during his lifetime is penalized. This is due to the fact that all of the years following the entrance of a wage earner into the Social Security System are counted as "elapsed years" and are used in determining his annual average wage, which is the key in figuring the basic Old Age and Survivors Insurance benefit.

**"It is our recommendation that in lieu of the approach embodied in Section 106, the committee give consideration to the more liberal formulas of most modern systems for computing benefits, such as those followed by most corporate pension plans and indeed by the government itself in the case of the Civil Service Retirement System."**

## Allman Appears Against Proposed Reinsurance Legislation

Washington, April 7.—Dr. David B. Allman, Atlantic City, chairman of the AMA Committee on Legislation, expressed the AMA's position on the reinsurance plan proposed by the Eisenhower administration before the House Committee on Interstate and Foreign Commerce.

Dr. Allman stated that the AMA is in accord with the purpose of the bill—to promote the best possible medical care on reasonable terms, but that the AMA doubts that H. R. 8356, the reinsurance bill, can accomplish the desired results.

**"The demonstrated ability of the (voluntary health insurance) industry to meet the needs and demands of the public indicates to us that it is unnecessary for the federal government to enter the field," Dr. Allman stated.**

### Some Not Insurable

He added that "it must be emphasized that there is a limit to the number of insurable people in this country, and a limit to what can be accomplished by insurance. In any effort to solve the economic problems of medical care, it is essential to consider two groups of individuals: (1) those who are able to pay the normal costs of medical care, and (2) those who are indigent.

"Most of the American people fall within the first group and have access to the many forms of health insurance now offered . . . As the desirability of insuring against medical expenses is more generally accepted and as the improvement and development of new types of coverage evolve, it is reasonable to expect that the maximum number of "insurables" will be covered.

**"The other group—the indigent—poses distinctly different problems. These individuals do not have the funds with which to purchase insurance and are dependent, in some measure, on outside assistance for the basic necessities of life. The American Medical Association believes that if the medical care problems of this group cannot be solved by the individuals or their families, the responsibility**

# Reinsurance Solves No Problems of Health Coverage, Say Spokesmen for Many Groups

Washington, April 9.—The American Medical Association was not alone in its opposition to the Health Reinsurance Fund bill before the House Interstate and Foreign Affairs Committee.

**Henry S. Beers**, speaking for American Life Convention and Life Insurance Association of America, said that because of the "many uncertainties" in the bill "we are not in a position to go on record in favor of the bill at this time."

**John H. Miller**, vice-president and actuary of the Monarch Life Insurance Company, appeared on behalf of the Association of Casualty and Surety Companies, the Bureau of Accident and Health Underwriters, and the Health and Accident Underwriters Conference. He said that reinsurance cannot be applied to a risk that is not insurable, does not help sell insurance and does not reduce the cost of insurance. It can do nothing for those not covered. He said direct assistance to low-income groups at the local level is to be preferred to the disguised federal subsidies contemplated in the reinsurance plan.

**Edwin J. Faulkner**, president of the Woodman Accident Company and two associated insurance companies, insisted the administration's program "would add nothing to the presently rapidly expanding and successful system" of private voluntary health insurance plans, and that it was a "first step in the direction of socialized medicine."

**Dr. Paul Magnuson**, chairman of the 1952 Truman Health Commission, said that the plan is not specific enough and would result in a mass of fine print in contracts when the administrators attempted to interpret congressional intentions. He also pointed out that the problem of the indigent was not helped by this bill, and that, as far as he knew, there are no indigent who cannot be taken care of in this country by existing local facilities.

The spokesman for the National Association of State Insurance Commissioners voiced strenuous opposition. He protested federal regulation as against state regulation of insurance and stated that "socialization of health services and undesirable federal subsidization of health insurance" would be inevitable.

CIO vice-president **Joseph Curran**, Dr. Morris Brand of the Amalgamated Clothing Workers of America, and James Brindle, social security director of CIO's United Auto Workers all expressed disappointment at the inadequacy of the proposal. They stated it "does not go far enough."

Opposition to the bill on the grounds it does not go far enough was also voiced by Nelson H. Cruikshank, for the American Federation of Labor and Dr. George Baehr, president and medical director of the Health Insurance Plan of Greater New York. William S. McNary, who spoke for the Blue Cross Commission and the American Hospital Association, said the bill was "a step in the right direction."

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should be assumed by the local and state government. . .

"We hope that expanded efforts by private agencies and an awakening by state and local governments to their responsibilities to the indigent will lead to a solution to the problem. It is not clear, however, how persons in the indigent group will be assisted by the provisions of the bill under consideration, without some form of federal subsidization paid through the insurance companies. We believe this would be objectionable. . . .

"As physicians . . . we do not feel qualified to comment authoritatively on (this bill's) technical insurance and reinsurance aspects. We have, therefore, in considering the bill, met with representatives of the insurance industry and have studied carefully their testimony before this committee during the past week. We have noted the reluctance and in some instances the expressed fear with which these insurance authorities have viewed the proposal.

"These and other expressions of opinions from the insurance industry, plus our analysis of the bill, have led us to the conclusion that a federal reinsurance system such as proposed by the bill could not be expected to achieve the objectives set forth in this legislation. . ."

# Racine County Children Get Salk Polio Vaccine

Madison, May 5.—Racine county took Milwaukee county's place as a trial area for the Salk polio vaccine. Dr. A. C. Edwards, city of Racine health officer, was in charge of the program for Racine county.

Milwaukee county originally was scheduled to take part in the trials, but backed out after a newscaster announced that live virus had been found in at least two batches of the vaccine.

The Milwaukee health officers said their county would participate if two conditions were met. One was that the vaccine be given to at least 100,000 children at least a month before being given to Milwaukee youngsters. The other was that at least 3,000 of the 100,000 should be given vaccine from the same batch used in Milwaukee county.

The State Board of Health refused to comply, stating that tests must be begun at once to be effective during polio season, and that special rules would have to be made for every county if one county was given special consideration.

Approximately 2,200 Racine county second grade pupils are receiving the trial vaccinations.

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

# Bill Authorizing Care of Servicemen's Dependents Is Introduced by Saltonstall

Madison, May 3.—The day after a delegation of five Wisconsin physicians discussed health care for dependents of military personnel with Washington officials, Sen. Saltonstall (R., Mass.) introduced a Department of Defense bill to accomplish this objective through military installations, private physicians, or insurance plans.

Basically, the bill, S. 3363, provides that dependents of armed forces personnel will receive medical and surgical care from military medical facilities except in emergencies or when military facilities are unavailable or cannot provide the kind of care required. The Secretary of Defense is granted authority to contract for dependent medical care under a private insurance plan, "if such action is deemed more economical."

In many respects the bill is not too far away from the policy of the American Medical Association regarding dependent care, but on one basic point there is disagreement: the Defense Department would have dependents receive private medical and hospital care only if they couldn't be handled in military facilities, whereas AMA would have them use military facilities only if care were not available from private sources.

The Saltonstall bill would make dependents eligible to receive diagnostic, acute medical and surgical, contagious disease, immunization, and maternity and infant care in military facilities. Excluded are "domiciliary care and chronic diseases; nervous and mental disorders, except for diagnosis; elective medical and surgical treatment; unnecessary ambulance service and home calls which are not medically necessary."

Prosthetic devices, hearing aids, orthopedic footwear and glasses are excluded, but "these devices may be furnished at government cost if they are available from military stocks."

If care can't be provided from military facilities, the dependents may obtain services from a civilian doctor or hospital according to a fee schedule to be set up by the Secretary of Defense.

Dependents will be required to pay the first $10 of the cost of each illness, whenever they use civilian facilities, plus not more than 10 per cent of the total cost, except in maternity cases for which there will be no charges. Dental care will be provided only in military facilities.

The proposed act applies to the wife (or husband), children, parents and parents-in-law of all enlisted or officer personnel, if the dependent receives more than half his support from the serviceman.

# STUDENTS SPONSOR CAREER GUIDANCE

Milwaukee, May 15.—Nearly 150 high school and college students attended the Second Annual Career Guidance Day sponsored by the Marquette Chapter of the Student American Medical Association.

Held on April 10, the Career Guidance Day provided students with first-hand information about the opportunities awaiting them in a medical career, the kind of high school and college courses which would best prepare a student for studies in medicine, and a preview of what medicine is doing today.

The career session was set up by Mr. Warren R. Belanger, chairman of the Committee on Medical Education, and David J. LaFond, president of the Marquette Chapter of the SAMA. The chapter planned a half day program including a tour of the school, discussions with faculty members and informal sessions with medical students. Publicity was directed to all Milwaukee high schools and colleges.

Those who attended the career day saw a 35-minute movie entitled "A Journey into Medicine," heard a 4-member panel discuss the liberal arts requirements for pre-medical education, toured the medical facilities at Marquette University and held small group discussions with medical students.

The unique feature of the career day was a survey of those who attended to determine their interest and suggestions for future career days. As might be expected, both high school and college students were interested in seeing more demonstrations and having a more thorough tour of the medical school facilities.

# Frequent Chest X-Rays Urged for Older People By Committee of SMS

Madison, April 11.—Special efforts to interest older age groups in the services of mobile chest x-ray units have been recommended by the Division on Tuberculosis and Chest Diseases of the Commission on State Departments.

The proposal comes out of a study of practices and coverage of mobile x-ray units. The study was discussed at a meeting of the Division, attended by Drs. H. A. Anderson, Stevens Point, Chairman; Helen Dickie, Madison; D. A. Gutheil, Whitelaw; F. B. Landis, Wood; Milton Feig, Madison; and A. A. Pleyte, Milwaukee.

The Division is recommending that all organizations operating mobile x-ray units be urged to coordinate their activities so that all units are fully utilized to maximum efficiency. Because of higher incidence of tuberculosis in older age groups, the Division is recommending that programs be planned to provide services to this older age group.

Statistics indicate a high incidence of cancer of the lung among the older age group, which the committee views as another reason for emphasis on x-rays in this field. Physicians are being urged to follow up closely all cases which are classified currently as "undetermined etiology."

# Mental Health Drive Lasts to End of May

Madison, May 8.—Mental Health Week was observed in Wisconsin May 2–8, by special proclamation of Governor Kohler. The mental health drive is to continue in the state until the end of May. H. R. Buckman, Milwaukee life insurance man, is campaign chairman. Finance chairman is Dr. Milton C. Borman, Milwaukee.

The Wisconsin Association for Mental Health has assisted in setting up guidance clinics, provided mental health education by means of community programs, radio, newspapers and television, organized chapters in various communities, and established institutes for ministers, teachers and community leaders who have occasion to deal with the mentally and emotionally disturbed.

# Review of 1953 Maternal Mortality Study Presented; Final Report to Come Later

DR. PURTELL

Madison, May 3.—Twenty-eight physicians attended a meeting of the Division on Maternal and Child Welfare of the State Medical Society's Commission on State Departments which met in Madison on May 2.

The study committee and interviewers who assisted with the maternal mortality survey in 1953 reviewed their findings concerning 66 maternal deaths in preparation for making a final report. The report is expected to outline proposals reducing the number of maternal deaths in the future.

**It was suggested that a basic review of the survey, with slides and supporting data, be made available to all members of the study committee and interviewers. These men would be available for staff conferences, county medical society meetings, special physician conferences such as meetings of the Academy of General Practice, and other physician education opportunities which may result in improving the prevailing practices of doctors and hospitals in the care of mothers.**

### Outline Program

The division outlined an expanded program for institutes on prematurity in hospitals not included in the initial pilot study. It also set up "teams" of obstetricians, pediatricians, and GP's in selected areas to study fetal and neonatal reports. The division will soon begin a pilot study among selected hospitals as to anesthesia practices in obstetrical cases.

Dr. Robert F. Purtell, Milwaukee, is chairman of the division. Also attending the meeting were Drs. Amy Louise Hunter, Madison; J. D. Wilkinson, Oconomowoc; and T. A. Leonard, Madison, all members of the Maternal and Child Welfare Committee.

Interviewers and study committee members who attended were: Drs. D. D. Willson, Fond du Lac; E. A. Birge, Milwaukee; George Hank, Madison; W. V. Luetke, Madison; S. D. Austin, Green Bay; J. J. Boersma, Green Bay.

Drs. Frederick Brown, Madison; Homer Carter, Madison; Florence Duckering, Sheboygan; Leo Grinney, Racine; G. S. Kilkenny, Milwaukee; R. J. Sanderson, Beloit.

Drs. George Stevens, Wausau; H. K. Tenney, Madison; T. W. Tormey, Madison; R. E. McDonald, Milwaukee; C. D Neidhold, Appleton; Elizabeth Steffen, Racine.

Drs. L. B. Stevenson, Madison; Marvin Wright, Rhinelander; E. D. Wilkinson, West Allis; A. H. Stahmer, Wausau; Donald Britton, Madison; and R. E. Campbell, Madison.

## WISCONSIN DELEGATION . . .

*(Continued from page 287)*

proposals for government provided care for dependents of military personnel and veterans with non-service connected disabilities.

**Father McGowan is chairman of a Hoover Commission committee appointed to explore the use of Blue Shield–Blue Cross and other insurance carriers for the medical and hospital care of persons in these groups.**

The Wisconsin doctors felt that increased pay rather than "fringe benefits" in the health care field would provide a more adequate solution to the morale problem in the Armed Forces. They urged Father McGowan's committee to get reactions from state medical societies, and to work more closely with local physicians and hospitals in instances where it appeared that some dependents of servicemen where not receiving needed care.

The trip also included interviews with Charles Crawford, director of the Food and Drug Administration, and members of his staff, officials of the Veterans Administration, discussions with the Wisconsin Senators and Representatives in Congress on a wide variety of pending legislation, and a visit to the Washington office of the American Medical Association.

Considerable time was spent with John Tramburg, director of the Wisconsin Department of Public Welfare who is on leave to Washington as Administrator of the Social Security Agency of the Department of Health, Education and Welfare.

# Annual Health Meeting Takes Place in Wausau

Wausau, April 8.—The annual Marathon County Health Conference took place at the Youth Building in Marathon Park, Wausau, April 8. Present were health officers, town chairmen, physicians, pastors, health chairmen of homemaker's and service clubs of rural Marathon county.

Dr. H. A. Schulz, Edgar, president of the Marathon County Medical Society, presided at the morning session when Dr. Horace K. Tenney, Madison, spoke on "Rheumatic Fever and Rheumatic Heart Disease." Dr. C. M. Yoran, medical director of Mt. View Sanitorum, spoke on Tuberculosis, and Miss Eileen Neidermeier, county home demonstration agent, on "The Heart of the Home."

Roger Maas, Marathon county supervisor for exceptional children, spoke on his work in the schools. Dr. G. G. Shields, Wisconsin Rapids, district health officer, presided over a discussion of "Team Work for Health and Sanitation."


**NEW HOPE**

**in the battle against**

**CANCER**

THE FIGHT against man's cruelest enemy is far from won. If present rates continue, 23 million living Americans will die of cancer—230,000 *this year*. And thousands of these will die needlessly—through cancer that could have been cured if treated in time.

ALL THE SAME, there have been victories. Thousands who once would have died are being saved—thanks, in part, to *your* donations to the American Cancer Society.

AND, LAST YEAR, the Society was able to allocate $5,000,000 of your donations to research aimed at finding the ultimate cure for *all* cancer. That's more money than ever before.

MUCH MORE, of course, remains to be done. So please make *this* year's gift a really *generous* one!

Cancer
MAN'S CRUELEST ENEMY
Strike back—Give
AMERICAN CANCER SOCIETY

# ASSOCIATION FOR PUBLIC HEALTH ELECTS OFFICERS

Madison, May 5.—At its annual meeting May 3 and 4 in Madison, the Wisconsin Association for Public Health elected H. J. Burger, Janesville Health Department Sanitarian, president for the coming year. He succeeds Dr. E. R. Krumbiegel, Milwaukee, city health officer.

Dr. Margaret Hatfield, district health officer, Elkhorn, was named vice-president and Paul Weis, Madison, director of vital statistics of the State Board of Health, secretary–treasurer. New members of the board of directors are Roderick F. Bott, district sanitary engineer, Chippewa Falls; Miss Belle Fiedler, district dental hygienist, Green Bay; and Miss Josephine Miller, Kenosha supervising nurse.

### Information on Polio

**The first morning of the meeting was devoted to information regarding the coming experimental polio vaccine tests and the evaluation of gamma globulin in polio prevention. Speaker about the vaccinations was Dr. Hart E. Van Riper, director of the National Foundation for Infantile Paralysis, New York, while Dr. Milton Feig of the State Board of Health spoke on gamma globulin.**

Speakers on cancer control who appeared the second morning were Dr. Paul B. Gerhardt of the New York State Health Department; Dr. Raymond F. Kaiser, National Cancer Institute, Bethesda, Md., and Dr. Gordon Worley, Jr., State Laboratory of Hygiene, Madison.

### Sectional Meetings

Sectional meetings covered maternal and child health, school health, health education, public health nursing, diarrheal diseases, laboratory and epidemiology; environmental sanitation, records and statistics.

Doctors who took part in these programs were Carl N. Neupert, Madison; Arthur L. Van Duser, Madison; Virginia Downes, Milwaukee; George M. Shinners, Green Bay; A. A. Pleyte, Milwaukee; R. H. Wasserburger, Madison; C. K. Kincaid, Madison, and Dr. Krumbiegel.

**DR. L. E. FAZEN, JR., Racine, was one of the first physicians to comply with the request at the end of the questionnaire for the IBM history card that each physician send in a picture of himself to complete his personal file. He posed with the Wisconsin Medical Journal for a special snapshot.**

# Questionnaires for Medical History Cards Go to MD's

Madison, May 6.—All members of the State Medical Society have received questionnaires designed to supply the information which will be punched into IBM history cards which are to be kept on file for each member.

A letter accompanying the questionnaire asked that the material be returned by May 10. All physicians who have not sent theirs in are urged to do so at once.

Question sheets have gone to all physicians, even members of long standing, because the society is anxious that its information be completely accurate.

The history cards will cover basic biographical data in addition to home and office addresses. They will include information regarding birth, marital status and family, medical education, internship, residency, licensure, degrees other than medicine, and previous practice before the present location.

A complete tabulation of the physicians' military service records will also be included. The cards will also show American Board certification, membership in specialty societies, type of practice, specialty, and method of practice, whether individual, partnership, etc.

Also to be listed are medical fraternal affiliations, positions held with hospitals, insurance companies and the like; immediate relatives in medical practice, and state and county society offices held.

These cards will be most helpful to the Committee on Medical Education and Hospitals and others in making studies from time to time. By means of the IBM system, statistical information can be tabulated with speed and accuracy.

# Estep Is Indicted for Mail Fraud in Dallas

Milwaukee, May 1.— A lecturer on health subjects who has addressed audiences in Milwaukee has been indicted by a federal grand jury. The jury charged William Estep with mail fraud and violation of the securities exchange act. The indictment was brought in Dallas.

Estep is accused of fraudulent statements in connection with sale of stocks in the Atomotor Manufacturing Co., Inc., of Texas. Stock was sold on the claim that proceeds would finance manufacture of a fuelless self-energizing motor.

About 70 persons bought stock on the representation that they would receive $1,000 return for each $1. invested.

Estep previously had been arrested in Texas on charges of violation of the state medical practice act.

# Lesions of the Lower Colon*

By PAUL L. SHALLENBERGER, M. D.
Sayre, Pa.

THE colon, being an organ of excretion and easily interfered with by mechanical or chemical means, is frequently the center of some disease process that is discovered comparatively late. The disease of importance involving the lower colon is cancer, and one must be constantly alert as far as this diagnosis is concerned. Too often there is much time and money consumed on drugs without even a digital examination of the rectum. Changes in function such as diarrhea or constipation are usually treated symptomatically, and then the colon may possibly be examined. The symptomatic treatment is one reason for late diagnosis. In the colon, as in the rest of the digestive tract, psychic disturbances result in change of function; and these symptoms are managed symptomatically without diagnosis.

I would like to point out several generalities of symptomatology and diagnosis of lower colon lesions before going into any discussion of specific diseases. First, the passage of blood in the stool is a symptom that the patient and the doctor both respect. Usually lesions of the lower colon that bleed show bright red blood, and this blood is not mixed with the stool but often streaks the outside of the stool. Right colon and small intestine and stomach bleeding are usually dark and often become tarry liquid in appearance and consistency. Bright red blood rarely passes through the bowel when hemorrhage occurs from a peptic ulcer. One should never forget that both hemorrhoids and a lesion may bleed at the same time. Patients are treated for months for bleeding hemorrhoids without so much as a digital examination, without a barium enema or a sigmoidoscopic examination. Yet disease in any part of the colon cannot be excluded with scientific exactitude without a digital examination, a sigmoidoscopic examination, and a barium enema. The lower 10 inches of the colon, the anus and rectum are poorly demonstrated by most x-ray studies. This is a comparatively blind area for other methods of examination but is easily visible through a sigmoidoscope. About one-half or more of the neoplastic lesions of the colon are within reach of the finger. It is not sufficient, therefore, in examining the colon to order a barium enema and consider it complete. Each form of examination complements the other and each is incomplete unless it follows the other.

The most common complaint after the passage of blood is that of diarrhea. A large percentage, probably three-fourths of the cases of malignancy of the transverse and descending colon, start with a change in bowel habit that includes diarrhea. The so-called neurogenic diarrhea and the diarrhea occurring from other types of infection and parasitic diseases is most difficult to distinguish by symptomatology. When an excessive amount of blood is passed in combination with diarrhea, one must suspect a neoplastic lesion or ulcerative colitis. The diarrhea that has been persistent for months or years in an individual who shows no nutritional or weight changes will help differentiate neurogenic from organic disease of the colon.

Pain is probably the most variable symptom in this group of diseases. At times a malignancy is so large that pain from obstruction, with cramping and the typical picture of beginning obstruction will be the presenting symptom. Lesions of the anus and first centimeters of the rectum may be associated with pain on movement of the body or a pressure sensation or frequently a repeated urge for defecation.

Pruritus ani will also be associated with these lesions and is also treated for months without further examination.

Weight loss is often a relatively late symptom and is at times not evident in observing the patient. Many patients with neoplastic diseases of the colon are greatly overweight to begin with, and they do not notice the loss of a few pounds early in their disease process.

With these factors in mind, I would like to discuss briefly each of the examinations. The digital examination can be performed in any of the classical positions; that is, in a lateral Sims position, in a knee-chest position, or on

* Presented at the One Hundred Twelfth Annual Meeting of the State Medical Society of Wisconsin, October 6, 1953.

a proctoscopic table. I should like to point out that the colon, particularly the recto-sigmoid portion is very redundant; and some lesions cannot be detected unless pressure is exerted against the examining finger by bearing down on the part of the patient. This is difficult on a proctoscopic table and is more successful in a lateral Sims position or as one would do a pelvic examination with downward pressure on the part of the patient. A sample of stool obtained during the rectal examination can be quickly checked for blood by smearing it on a piece of filter paper and using the ordinary detection tests. No physical examination is complete without this digital examination. One digital examination does not last forever in the management of a patient.

The sigmoidoscopic examination is one of the most valuable of all types of endoscopy or physical examination technics. If one is considering carcinoma sites and the ability to recognize and locate the lesion, he will find that a sigmoidoscope will give more positive results than the stethoscope. It has been estimated that about 15 per cent of both male and female cancer deaths in the United States in recent years were from cancer of the intestine. Approximately two-thirds of all of these cases could be detected, diagnosed, and proved by one examination with a sigmoidoscope. We have recently completed an analysis of 4,500 consecutive sigmoidoscopy examinations. These were in unselected cases of all ages, both sexes, and some without gastrointestinal complaints. Sixty-five per cent of these examinations revealed some abnormality. What other examination, including x-ray, history, physical examination, or routine laboratory work will result in such a high percentage of findings? It is, of course, true that many of these abnormalities are minor and of little or no significance and demand little treatment. Too many people have considered the sigmoidoscopic examination to be the property of a specialist. It is my considered opinion that it should be a part of the diagnostic armamentarium of every practicing physician. A minimum of training and observation will result in the acceptable use of this instrument.

Elaborate preparation and elaborate equipment are not necessary and in general contribute only to the comfort of the examiner and not that of the patient. If first seen after the early morning hours, more than half of the patients can be successfully examined without any preparation. Of the rest, a large number can be examined later in the day without any preparation. If one needs to prepare a patient and can demonstrate no contraindications, castor oil and enema preparation is helpful in viewing the mucosa. A special table is not necessary. We have made the examination in the knee-chest position or even on the floor. Instruments are secondary, and one may use either a proximal or distal lighted instrument depending upon his own preference.

All neoplastic lesions should be biopsied when seen. In our group of 4,500 consecutive examinations, tumors were demonstrated in 454 cases, or approximately ten per cent of the total. Of these, 336, or seven and one-half per cent, were benign; and 116, or 2.6 per cent, were malignant. I should like to point out that all of these tumors were biopsied. This point should be emphasized because the literature is filled with articles giving statistics on neoplastic diseases of the lower colon based upon visual detection and fulguration of some lesions, with biopsies of others. When we further analyzed our statistics from the point of view of gross diagnosis, we found that 330 of these tumors were both grossly and microscopically benign; and 89 were grossly and microscopically malignant. We were wrong, however, in 27, or 7.6 per cent, of the grossly benign cases, which turned out to be microscopically malignant. We were again wrong in 6 out of 95 cases where the lesions appeared grossly malignant but were microscopically benign —a percentage of 6.3. If this is our error after considerable experience covering many thousands of examinations, what might one expect with the occasional examiner who is trying to make a visual diagnosis without the benefit of microscopic tissue from biopsy?

There is nothing very difficult about making a biopsy if one has forceps. A small sessile polyp can be, and usually is, completely removed for purposes of the biopsy. A snare will, in most cases, remove a polyp on a pedicle. If one observes the point of removal, bleeding can be detected and stopped by cotton pledgets saturated with ferric sulfate and tannic acid. A cautery at times will be necessary but is not essential. In only four cases have we found bleeding as a later complication. These were cases in which we removed polyps with long stalks and with well-

organized blood supplies which were insufficiently controlled at the time they were removed. Cultures from inflamed bowels can be obtained directly from the bowel mucosa, and parasites and ova can be obtained by aspiration. This examination and the technic of biopsy can be considered safe and comparatively free of complications. Our examination technic has resulted in about 85 per cent of the examinations being considered successful in terms of penetration to a depth of 8 inches or more. The remaining 15 per cent have been clinically satisfactory with a few exceptions but have not been considered completely successful because of the depth of the examination.

The benign lesions of the anus, rectum, and rectosigmoid are usually self-evident when seen. A polyp, for instance, is not easily confused with anything else, and most carcinomas look malignant. Minute or minor changes in the bowel mucosa can be and often are misinterpreted as to significance. While color changes and appearance of granulation may indicate a chronic stage of ulcerative colitis, they sometimes represent only the effects of preparation. Hemorrhoids, particularly the internal type, were demonstrated in about 45 per cent of our cases. External hemorrhoids, on the other hand, represented only 15 per cent. Various conditions of the papillae, including fibrosed or inflamed papillae with or without associated fissure, proctitis, prolapsed rectal mucosa, etc., represented about 51 per cent of the total pathology encountered. The overlapping of these figures represents cases where both conditions were found.

Follow-up examination is often neglected. When polyps have been removed, we advise the patient to have a repeat sigmoidoscopic examination within 3 months. If, at that time, polyps are again detected and removed, the patients are further advised to repeat the examination in another 3 months. All patients in whom polyps have been found are advised to have an air contrast barium enema immediately. Isolated polyps in the upper colon above the area where the sigmoidoscope can detect their presence may be demonstrated by this means. They produce few, if any, physical findings and very few symptoms. In the light of our present knowledge, one must consider them precancerous, and the only safe management is that of surgical removal. Diffuse polyposis of the colon is another clinical pattern which, as a definite precancerous lesion, should be treated surgically.

In preparation for the barium enema, one must use more care with the patient. A clean mucosa and a completely empty bowel is essential. In the absence of obstruction and bleeding, we use an ounce and one-half of castor oil and an enema at bedtime and an enema in the morning. When a space-occupying lesion is detected under the fluoroscope and a tentative diagnosis of an isolated colon polyp or cancer is made, one should proceed with caution before surgery is undertaken. Too often, foreign substances such as hard fecal masses will cling to the colon walls and resemble tumors. We have thought it necessary to reproduce the pattern of the lesions in at least 2 examinations before proceeding surgically with removal of the lesion. I should like to point out, also, that if one discovers a lesion through the sigmoidoscope, it does not mean that this is the only lesion. Double lesions of the colon are not infrequently encountered, and it is extremely important for the operating surgeon to know if more than one lesion exists.

The irritable colon syndrome is a functional pattern often existing as a primary condition in its own right but also sometimes being secondary to other intra-abdominal disease. This represents psychosomatic dysfunction of the bowel with pain, alternating diarrhea and constipation, resultant abuse of laxative or enema, and increased mucous passage. It is a problem often associated with peptic ulcer, gallbladder, and pancreatic diseases and may often produce prolonged symptoms after the basic pathology has been alleviated or removed. This group of patients is usually tense, nervous, suggestible and unstable. One is dealing with the most difficult class of patients seen. Diagnosis must, therefore, be made partly by excluding associated diseases. Careful reassurance, handling, and understanding of the underlying problems is a further essential. Physical as well as mental trauma should be avoided. Eliminating laxative abuse and enemas and correction of the diet, with particular emphasis on fluid intake, are necessary parts of the management of these patients.

The infectious diseases, such as those caused by the parasitic and bacterial organisms, are a field of their own and will not be covered in this paper except to mention the

need for recognition before management is undertaken.

Ulcerative colitis is a specific disease pattern, the etiology of which is completely unknown and the treatment of which is about as controversial as anything in medicine. About all one can say about this disease at the moment is that surgery is for its complications while medical management consists of symptomatic therapy with "tender, loving care" of the patient and understanding of the disease process.

Malignant lesions, both in their premalignant stage as polyps and in their advanced stage as malignant tumors, should be considered in all cases where presenting symptoms of the patient are concerned with the bowel. Few ages are immune from this condition. Polyps have been found in young children and are found in older people in about 7 per cent of all cases examined by sigmoidoscope or x-ray.

After diagnosis as such, malignant lesions of the colon should be treated surgically. Resection of the lesion that is safely accessible above the peritoneal reflection and an abdominoperineal resection for those below the peritoneal reflection seem to be the surgery of choice.

I should like to outline briefly a few cases which give some illustrations of the tumors seen.

### Case Reports

*Case 1*—A 64-year-old man complained of bleeding from the rectum for six months. He had received numerous ointments for hemorrhoids.

Sigmoidoscopic examination showed a cartilaginous, cauliflower, ulcerating lesion at 4 inch depth. An abdominoperineal resection was performed. Biopsy revealed an anaplastic adenocarcinoma. Recent examination shows the condition to be probably recurrent.

*Case 2*—A 73-year-old female was admitted to the hospital and complained of upper abdominal pain and diarrhea. Physical examination findings were essentially negative except for midabdominal tenderness and evidence of weight loss. Sigmoidoscopic examination findings were negative, but a barium enema revealed a double lesion, plus two large polyps. One lesion was in the cecum and one in the transverse colon. Resection was done to correct both.

*Case 3*—A 74-year-old female complained of pruritis ani of 2 years' duration and of the passage of blood for 3 months. There was no pain or weight loss. Digital and sigmoidoscopic examination with biopsy revealed an epidermoid carcinoma (Bowen's disease). The condition was treated with radon seed and is nonrecurrent after 2 years.

*Case 4*—A 64-year-old male was admitted to the hospital with vague abdominal distress and backache. There was a history of small spots of bright blood in the stool, a questionable weight loss, and a long period of laxative use.

Sigmoidoscopic examination showed a polyp at 4 inches which was removed and found benign and a carcinomatous lesion at the rectosigmoid junction. Biopsy showed malignant cell adenocarcinoma. Resection was done. To date, 2 years after resection, the patient is alive and well.

These examples illustrate several of the points made previously and show the frequency of double lesions and the association of benign polyps with malignant lesions.

At present our only practical approach to the cancer question is early detection and removal. Without wide medical use of examination technics and a constant alertness to cancer, we cannot hope to improve our results and increase the cure rate.

### Summary

In conclusion I would like to re-emphasize several points of importance.

1. A complete examination of the lower bowel must include digital, sigmoidoscopic, and x-ray studies.

2. Routine bowel examination, particularly in the adult patient, should be started when symptoms that indicate bowel changes develop.

3. Hemorrhoids may exist but not bleed, and bleeding from lesions above may occur while hemorrhoids are silent.

4. Symptomatic treatment of hemorrhoids, pruritus ani, and other local anal disease should not be started or continued unless the bowel has been examined above the local lesion.

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Guthrie Clinic.

# Diagnosis of Shoulder Pain*

By MARK B. COVENTRY, M. D.**
Rochester, Minn.

PAIN in the shoulder is one of the most common complaints encountered in private practice. Among symptoms referable to the skeletal system, it is probably exceeded in frequency only by the complaint of backache. Determination of the cause of shoulder pain is often a difficult, although stimulating, problem. Each patient is a challenge to the physician's diagnostic ability. Pain in the shoulder, for example, may not necessarily be caused by intrinsic disease in the shoulder, but may arise elsewhere; and a careful evaluation of each patient who complains of shoulder pain means more accurate diagnosis and thus more rational treatment.

It would be manifestly impossible to discuss in detail all the causes of shoulder pain. The cause of pain in the shoulder may be categorized under musculoskeletal, neurologic, visceral, and peripheral vascular conditions. Only the more common problems of intrinsic shoulder lesions, the cervical syndrome, and periarthritis will be considered in this paper.

### Intrinsic Shoulder Lesions

The conjoined tendon, composed of the insertions of the supraspinatus, infraspinatus, teres minor, and subscapularis muscles into the greater tuberosity of the humerus, is the so-called musculotendinous, or rotator, cuff of the shoulder. These muscles rotate the humerus on the scapula; and their combined contraction "sets" the head of the humerus in the glenoid cavity, allowing the deltoid muscle to perform abduction. Degenerative changes occur early in these tendons. The basic reason for this is the upright posture of man, which causes strain in the form of gravitational forces on the musculotendinous cuff and friction on this cuff as it rubs against the acromion process and the coraco-acromial ligament. Calcareous deposits and partial and complete tears of the shoulder cuff result from degeneration. These degenerative lesions, plus the purely traumatic sprains and strains, constitute the most common causes of shoulder pain.

The lesions due to degeneration in the musculotendinous cuff are more properly termed "tendinitis," although they are popularly known as "bursitis." Codman[1] emphasized the role of the subacromial bursa, but it is my opinion as well as that of others that bursitis of the shoulder is the result of degenerative change in the tendons and is a secondary phenomenon. Withers[2] has compared the subacromial bursa to the peritoneum, stressing that inflammation of the bursal sac is analogous to peritonitis, which is not usually a primary pathologic state but a result of disease elsewhere. The subacromial bursa, the largest bursa in the body, is in intimate relationship to the musculotendinous cuff of the shoulder and to the long head of the biceps tendon. In this location it may be involved as a secondary manifestation of lesions of these tendons, although this is rare. I routinely remove portions of the bursa while operating for calcareous deposits in the supraspinatus tendon, and the pathologist rarely finds microscopic evidence of inflammation in specimens submitted to him.

DePalma and his co-workers[3] have shown that, by the fifth decade of life, degenerative changes are common in the musculotendinous cuff and in the long head of the biceps tendon. While osteoarthritic processes are not so common in the shoulder joint as in a weight-bearing joint, the scapulohumeral and acromioclavicular joints frequently are narrowed because of degeneration of the articular cartilage; and osteophytes may occur along the articular margins.

While the primary process in the musculotendinous cuff appears to be one of attrition, trauma does play a role in many cases. Patients frequently give histories of some type of injury preceding the onset of pain in, or rupture of, the tendon. The situation is analogous to protusion of an intervertebral disk or to inguinal hernia, in which the basic defect is degeneration of the tissues, and trauma is only a precipitating factor.

* Read at the meeting of the Wisconsin Academy of General Practice, Milwaukee, Wisconsin, November 17 and 18, 1953.

** Section of Orthopaedic Surgery, Mayo Clinic.

*Diagnosis*—The diagnosis of intrinsic lesions of the shoulder depends partly on an adequate history. The onset of severe, acute, motion-limiting pain in the shoulder usually indicates an acute calcareous tendinitis. In this condition, chronic pain may have occurred for months or years before the onset of acute pain. Tenderness is usually present over the involved tendon, which is, as a rule, the supraspinatus tendon, although the pain itself may be more generalized and referred down to the attachment of the deltoid muscle. Motion, especially abduction and internal rotation, is limited in all directions; and swelling may occur occasionally. Roentgenograms reveal calcareous deposits in the musculotendinous cuff. These deposits are sometimes difficult to find; and roentgenograms should be made in two or more projections, for the head of the humerus may be superimposed on the calcareous deposit, partially obscuring it. Calcareous deposits occur only rarely in the subacromial bursa and can be readily recognized by their anatomic location.

Attritional changes without calcific deposit present the same clinical picture but give no roentgenologic evidence of calcareous changes. Tenderness is usually present over the degenerated portion of the tendon and, as in calcareous tendinitis, the pain may be referred into the insertion of the deltoid tendon or farther down the arm to the hand. Motions are not limited, except by pain, unless the complication of periarthritis has developed.

When the diagnosis is difficult, injection of procaine hydrochloride (Novocain) into the tender areas will help solve the problem. If the injection is made directly into the tendon and relief of all pain is achieved, especially on full abduction and rotation, the diagnosis of a lesion in the musculotendinous cuff is justified. If, furthermore, the patient is unable to abduct the humerus before the injection but can afterward, the musculotendinous cuff is relatively intact. Conversely, if the patient is unable to abduct even if pain has been relieved, a complete tear of the musculotendinous cuff probably is present; and surgical repair is required. One must keep in mind, however, that injection of anesthetic agents into "trigger" zones secondary to cervical radiculopathy also tends to relieve the pain. These latter regions, however, usually are subcutaneous and not in the tendon.

Laboratory aids, except for roentgenograms, are not particularly helpful. In a study of 100 consecutive cases of painful shoulder, it was found that the erythrocytic sedimentation rate usually was increased to a mild degree in acute forms of calcareous tendinitis and in periarthritis, the average value being about 25 mm. during the first hour (Westergren method). Other conditions, such as rheumatoid arthritis or tumors involving the shoulder, must be considered in the differential diagnosis. By their elimination, the diagnosis of a lesion of the musculotendinous cuff or long head of the biceps tendon is strengthened.

### The Cervical Syndrome

The initial cause of pain in the shoulder often may be irritation of the roots of the cervical nerves. Jackson[4] has called this the "cervical syndrome," and she considers it to be the most common cause of pain in the shoulder. The radiculopathy may be mechanical or inflammatory. A history of trauma, such as a fall on the head or a whiplash injury in an automobile, is commonly elicited. This may have occurred many years previously, with subsequent bouts of stiff neck or "crick" in the neck and aching pain in the region of the trapezius muscle or the scapula or in the deltoid region, with frequent extension into the arm, forearm, and hand. Results of physical examination of such patients are frequently within normal limits. Pain in the neck with referral into the shoulder may be caused by hyperflexion or hyperextension of the neck. Pressure on top of the head while it is rotated to the right or left also may cause reproduction of the pain. Objective evidence of irritation of nerve roots may be present, with paresthesia, anesthesia, and occasionally motor involvement, with diminished reflexes or atrophy or both. However, the results of examination of the central nervous system more frequently are normal. "Trigger" points may be found. They may be in the occipital region, accompanying the frequent headache of which these patients complain; or they may be over the scapula or the deltoid muscle.

Roentgenograms of the cervical portion of the spinal column do not always bring out the minor subluxations that may occur in the cervical apophyseal joints. Capsular changes in the lateral intervertebral articu-

lations are thought by Jackson to be important and a cause of radiculopathy. While the presence of degenerative lesions in the cervical portion of the spinal column is common and can be found in almost every patient more than 40 years of age, nonetheless the role of such lesions should be carefully assessed. Narrowing of intervertebral disks with or without osteophytic formation, hypermobility demonstrated by roentgenographic views during flexion and extension of the cervical portion of the spinal column, and encroachment of intervertebral foramina are all important signs when coupled with the history. Posture during work and play and the occupation of the patient are often significant factors. Both flexion and extension cause pressure or strain on the roots of the cervical nerves. If the patient is questioned as to just when his pain occurs, the cause frequently will be evident. Traveling salesmen who drive excessively will notice that the pain comes while they are fatigued and while their necks are either hyperextended or hyperflexed. Typists working over their desks frequently give the same story. In some patients the pain occurs at night, due to faulty posture while sleeping. A frequent cause is reading in bed with a pillow propped behind the head, causing hyperflexion of the cervical portion of the spinal column. The patient often spends a painful night after such pleasure and has pain in the shoulder and neck the next morning.

All observers are not in agreement concerning the role of intervertebral disks in the cervical syndrome. Eaton[5] was of the opinion that most cervical radiculopathy is caused by protrusion of an intervertebral disk, while Jackson stated that an extremely small amount of this syndrome is produced by such protrusion. In any event, operative procedures are seldom indicated; and the conservative measures of traction, heat, and attention to posture will handle most of these problems.

### Periarthritis

I would like to define periarthritis as a state of pain and stiffness in the shoulder. The stiffness is due to periarticular fibrosis; and motion, therefore, is limited not just by the pain of the condition but passively as well. Periarthritis may occur in one of three phases: (1) slightly limited motion with usually predominant pain, which is the early form of the condition; (2) great stiffness, with little or no scapulohumeral motion, which is the so-called frozen shoulder; and (3) the shoulder-hand syndrome, in which the shoulder may be involved in any state or degree of stiffness and the hand is involved in a similar manner. There are swelling; redness or bluish changes; shiny texture of the skin; stiffness in the joints of the fingers; and swelling, tenderness, and nodularity of the palmar fascia. Typical Dupuytren's contractures are observed in the later stages.

The development of periarthritis in the shoulder is dependent on the presence of three factors. First is pain of any sort, due to the causes already detailed or to any cause whatsoever. This is the instigating factor that sets off the entire process. However, pain in the shoulder will not lead to periarthritis unless two other factors are present; namely, an emotional pattern which I have termed the "periarthritic personality," and disuse, with its accompanying sympathetic nerve changes. These factors have been discussed in detail elsewhere.[6-8]

The periarthritic personality is a particularly striking entity and will be evident if one delves into the background and emotional make-up of the patient. Persons in whom periarthritis develops because of pain in the shoulder usually have passive, apathetic attitudes. They are frequently tense and generally fatigued. Their tolerance to pain is poor. They are hyperemotional and exhibit hyperactive vasomotor responses. They lack drive and are dependent on others for initiative and decisions. These emotional problems should be investigated in any patient suffering from periarthritis, and a conscious effort should be made to stimulate the patient to use his shoulder and thus help in recovery. With kindness and sympathy, yet a firmness of attitude, the physician can speed the restoration of the periarthritic patient to health.

The mere fact that this type of person refrains from using the upper extremity because it hurts may be the reason that capsular adhesions of the shoulder and palmar fibrosis develop. However, the capsular and palmar fibrosis may be due to reflex disturbances in the sympathetic nervous system of the upper extremity, causing secondary circulatory and trophic changes. Regard-

less of the exact mechanism, however, the clinical picture is indistinguishable from classic reflex sympathetic dystrophy. If the condition involves the hand, the changes are obvious, as mentioned previously. When the changes involve just the shoulder, they are less evident because the structures involved are deeper. The capsule is under a fairly heavy layer of fat and muscle, and its examination cannot be carried out as accurately as can that of the palmar fascia. The changes in the shoulder are similar to the changes in the hand. The fibrous capsule of the shoulder contracts after an early period of painful swelling, just as does the palmar fascia; and stiffness results later.

Immobilization in a cast or splint is frequently enough to precipitate the condition of periarthritis. In such cases, pain may not be a highly obvious feature. One should be particularly careful in dealing with persons who have a tendency toward the periarthritic personality to mobilize the shoulder, wrist, and fingers as rapidly as possible in the management of any condition that affects these regions. Fractures of the surgical neck of the humerus and Colles' fractures are prone to result in this state of disuse atrophy if measures to induce mobility are not undertaken early.

The early recognition of the development of periarthritis is essential, for treatment is most difficult once periarthritis becomes full-blown and the patient has a frozen shoulder or the shoulder-hand syndrome. One should recognize that any pain in the shoulder is a potential cause of periarthritis and that the development of periarthritis is almost inevitable if a condition of disuse is coupled with the emotional state that has been described. Early measures to mobilize the shoulder, with every effort to relieve the pain so that the patient may use the shoulder more freely, should be undertaken.

## Summary

The two major conditions that may cause pain in the shoulder are intrinsic lesions of the shoulder itself and the cervical syndrome. The diagnosis of these conditions has been discussed. Periarthritis of the shoulder may result from pain of any cause and is particularly refractory; thus, its early diagnosis is imperative.

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Mayo Clinic.

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## INVITATION TO WAIKIKI

The Hawaii Medical Association cordially invites all physicians and surgeons to take the Post AMA Convention Tour to Hawaii and attend the scientific sessions in Honolulu on June 28 and 29, 1954.

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# Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

## REPORT OF A CASE*

This fifty-year-old white male was admitted to the hospital and complained of weakness and swelling of the legs of a year's duration. The swelling would recur from time to time and would subside following rest and saline catharsis. In the past 2 months, however, swelling had become persistent and had involved the genitals and later the arms. The swelling was troublesome, making walking difficult.

*Functional inquiry.* The patient had slight exertional dyspnea without orthopnea or nocturnal dyspnea. He had had a chronic cough, usually productive of white sputum, occasionally of yellowish sputum, for many years. His appetite had been good until recently. The patient had 3 square meals a day. He drank a case of beer and a pint of whiskey per day for 15 years. He denied jaundice or bloody stools; his urine had been dark recently. A year ago he had been told by a private doctor that he had high blood pressure and kidney trouble. He had had 6 episodes of pleurisy and pneumonia in the past.

Physical examination revealed a blood pressure of 96/54, pulse of 104. The patient was oriented and cooperative and in no apparent distress save for mild dyspnea.

*Positive physical findings:* The neck veins were distended in semirecumbent position. The lungs were slightly hyperresonant with medium fine, moist rales through the lower half of the lung fields. The heart was regular with distinct tones; it was considerably enlarged. There appeared to be a pericardial rub, best heard to the left of the sternum in the fourth or fifth interspace, the aortic second sound being equal to the pulmonic second sound. The abdomen was soft. The liver was palpated one fingerbreadth and was nontender. There was edema of the abdominal wall, the scrotum, the back from the scapula down, and both upper and lower extremities.

*Neurological Examination:* There was suggestive weakness of the right arm and hand; otherwise, findings were not remarkable.

*Admission laboratory work:* Hemoglobin, 11.5; red blood cell count, 3.8; color index, 0.98; white blood cell count, 9,600, with stabs 25, segmented 65, eosinophils 1, lymphocytes 3, and monocytes 6. The urine was amber, acid, showed specific gravity of 1.013, was negative to 1+ for albumin and negative for sugar and cellular elements. Nonprotein nitrogen was 40.5 mg. per cent; chloride, 79 mEq.; carbon dioxide, 12.2 mEq.; sodium, 115 mEq.; potassium, 4.85 mEq.; bilirubin, 1 minute, 2.5 mg. per cent, total, 4.2 mg. per cent; and total protein, 5.5 Gm., with albumin 2.2 Gm. and globulin 3.3 Gm.

The following day the patient was confused as to time and appeared lethargic. Questionable icterus was noted in the sclerae. The impression was cirrhosis of the liver with possible nephrotic syndrome and renal acidosis. Later in the day the patient became very delirious and was placed in restraints.

X-ray showed a suspicious fibrotic infiltration of the fifth anterior interspace. The remaining lung fields were within normal limits.

Repeat chemistries two days later showed chloride, 79 mEq.; nonprotein nitrogen, 45 mg. per cent; carbon dioxide, 13.5 mEq.; sodium, 115.5 mEq.; potassium, 4.4 mEq.; total cholesterol, 93 mg. per cent; and cephalin flocculation, 3+.

The patient's temperature rose to 106 F. (R). Grating sounds in the fourth interspace were now absent, and rhythm was regular. A systolic grade II murmur was noted in the aortic area. Another examiner noted that there was a definite scleral icterus. Reflexes were hypoactive. A Levine tube was inserted, and 500 cc. of port wine fluid was removed from the stomach. A later notation stated that the patient had rectal passage of black-colored material of watery consistency. Shortly thereafter the patient suddenly turned cyanotic, and respirations ceased.

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Clinical Discussion

**Dr. S. Marks, radiologist:** There are suspicious fibrotic infiltrations in the second right anterior interspace; however, the remaining pulmonary fields are essentially within normal limits. We did not have an opportunity to re-examine the patient, and we do not have any further opinion concerning the area of suspicion. It might represent tuberculous disease or some insignificant change.

*Question:* What about the heart size, Doctor Marks?

**Doctor Marks:** The heart is slightly enlarged as evidenced by the right border of the cardiac silhouette.

*Question:* Doctor Marks, is there much change in the size of the heart if the roentgen picture is gotten at the time of systole versus the time of diastole?

**Doctor Marks:** There is some variation in the size of the cardiac silhouette, but on a teleo-film it is not nearly as marked as the impression one may gain from fluoroscopic examination.

**Robert B. Callahan, student:** I do not believe that the nephrotic syndrome needs any consideration in this case because the patient had neither heavy proteinuria nor hypercholesterolemia, which by definition are part of this syndrome. The low cholesterol was probably due in part to the general dilution of the body fluids seen in this patient. If there was any kidney malfunction, it was only secondary to congestive failure.

There is sufficient evidence from the history, liver enlargement, and laboratory liver function tests to say that this patient had cirrhosis; but I do not think that this was the most important factor in causing the edema. Congestive failure seems to have been more important.

In view of the x-ray findings in the lung, active tuberculosis must be considered. In addition, there seems to have been a pericarditis which may have been tuberculous in nature.

Another possibility suggested by the pericardial friction rub is an atypical case of myocardal infarction in which pain was minimal or absent.

Actually, it seems to me that the most interesting aspect of this case is the marked derangement of the electrolytes. Comparing the findings with normal values, it is seen that carbon dioxide was down to 12 mEq. from a normal of 27, sodium was down from 142 to 115 mEq., and chlorides were down from 102 to 79 mEq. This is a picture of severe acidosis with water intoxication. When we try to balance the cations and anions, we find that the inorganic acid anions must have been elevated to at least 18 compared to the normal of 6.

In attempting to account for these findings, I thought it might be related to the patient's unusual treatment for edema. I have never heard of using cathartics, but apparently by violent purging he got rid of enough water, salt, and other electrolytes to temporarily relieve the edema. By such a method, he lost both sodium and chloride as well as the alkaline intestinal secretions. In this speculation, I assume, of course, that the fluids were replaced by water without salt (case of beer per day), thus leading to water intoxication. Possibly he was on a "cathartic binge" for several days prior to admission.

**Rouben Akka, student:** This fifty-year-old white male who appeared poorly nourished entered this hospital with the chief complaint of weakness and swelling of the legs of one year's duration. This edema would subside after a rest and his saline cathartics. In the last 2 months, the edema had become persistent and more generalized. The patient said he drank a case of beer and a pint of whiskey per day for 15 years. With so much drinking, I do not see how he could have had "3 square meals a day." From this much drinking, his appearance, and the hypoproteinemia I think I can safely assume that he had severe malnutrition. A year prior to his admission, his private doctor had told him that he had high blood pressure. In this admission, he had a blood pressure of 96/54, which I consider hypotension in this patient. The moist rales in the lower half of the lung fields, the distended neck veins, and his cardiac picture indicate heart failure and increased pulmonary pressure. The liver was slightly enlarged and non-tender. This, along with his chronic alcoholism, indicates to me liver cirrhosis.

The laboratory findings are helpful in this case. They show that the patient is slightly anemic. The white blood cell count is within normal limits, but the differential indicates an infection somewhere. His nonprotein nitrogen of 40 mg. per cent may be considered slightly elevated or as the highest limit of normal, but I consider the repeated nonpro-

tein nitrogen of 45 mg. per cent as slightly elevated. His low sodium of 115.5 mEq. per liter and his low chloride and carbon dioxide combining power indicate to me that this patient is suffering from a low sodium syndrome. This syndrome is associated with prolonged malnutrition, cirrhosis of the liver, cardiac failure, advanced tuberculosis, and other conditions. The chest x-ray does not give evidence of advanced tuberculosis, but this man gave a history of prolonged malnutrition and showed clinical evidence of liver cirrhosis and cardiac failure. The low sodium syndrome can account for most of the symptoms and signs in this case. Along with the low serum albumin, it can account for this patient's prolonged edema. This syndrome can also account for the weakness, lethargy, and confusion of the patient; anorexia; tachycardia; hypotension; acidosis; and the slight elevation of nonprotein nitrogen. The low chloride and carbon dioxide may be a compensation for the decrease in the sodium level. The elevated serum bilirubin and the scleral icterus indicate hepatocellular damage and are compatible with liver cirrhosis.

The reason why the sodium and the other electrolytes were so low is that the patient's large intake of fluids—and, of course, the output, too—was practically washing out and depleting him of his electrolytes Also, the dilution of the electrolytes in his body by the increased volume of fluid may be partially responsible for the low sodium, chloride, and bicarbonate levels of the serum.

The patient went downhill. His cardiac picture became worse. Five hundred cubic centimeters of port wine fluid were removed from his stomach. I suppose this was blood. Since he had a clinical picture of liver cirrhosis, he could have had ruptured esophageal varices. This may also explain the black-colored stool which he passed before he expired.

My diagnosis is malnutrition, resulting in low sodium syndrome; chronic alcoholism, resulting in cirrhosis of the liver; and heart failure.

The cause of death was probably ruptured esophageal varices and heart failure.

**Ernest Epstein, student:** How does this explain the peculiar electrolyte picture? Both the sodium and chloride are quite markedly and about equally reduced. There is marked acidosis as shown by the decreased carbon dioxide combining power of the blood. Also, if one adds up the principal cations, sodium and potassium, and subtracts from them the principal anions, chloride and bicarbonate, one gets a great difference in the milliequivalent balance. This gap between the concentration of cations and anions is considerably greater than that found normally. What is the explanation for this? Is there increased sulphate or phosphate retention or possibly some increase in acid metabolite?

**Dr. Earl Schulz:** On admission, this fifty-year-old white male presented a problem in the differential diagnosis of generalized edema. One year ago the edema had been intermittent and confined to the lower legs, but it had gradually become more extensive and more persistent. In the 6 to 8 weeks preceding admission, it was almost always present and involved the arms, abdominal wall, and genitalia as well as the lower extremities. In addition, there was associated anorexia, weakness, and dyspnea both at rest and on exertion. The three most probable etiologic factors of the anasarca which were considered were cardiac, renal, and hepatic disease. Since the pateint was disoriented throughout most of his short hospital course and his relatives knew little about him, some essential information is lacking in the history. The patient's condition did not permit the extensive laboratory diagnostic studies which were desired.

Let us consider first the possibility of cardiac disease as a cause of the generalized edema. There was no definite history of rheumatic fever in childhood or early adult life, but as a boy the patient supposedly had "St. Vitus' dance." One year prior to admission, the patient had been told he had high blood pressure. However, on admission, his blood pressure was 96/54 and throughout his hospital stay the highest recording was 100/60. Funduscopic examination showed only minimal arteriosclerotic changes. On physical examination, the heart was slightly enlarged to the left and a grade one apical systolic murmur was heard. A normal sinus rhythm was present. The friction rub which was heard on admission was not heard again and cannot be adequately explained. Scattered moist rales were heard in the lower lung fields, but the chest film did not show the picture of pulmonary congestion. The liver was palpable only one fingerbreadth below the costal margin and was non-tender. Because of absence of a demonstrable valvular

**Fig. 1—Photomicrograph of liver showing enlargement of the central vein with disorganization-necrosis of the central areas. There is fatty degeneration of the peripheral portions of the lobules, however, without any significant portal change.**

lesion, hypertension, significant hepatomegaly, and pulmonary edema, the generalized edema was not felt to be due primarily to cardiac disease.

If renal disease were the cause of the anasarca, the most likely disease would be the nephrotic stage of chronic glomerulonephritis. There was no known history of kidney disease other than one year ago when a physician informed the patient that he had "kidney trouble." The nephrotic syndrome is characterized by heavy albuminuria, hypoproteinemia, and hypercholesterolemia. On casual urine specimens the albumin was recorded as negative and on one occasion as 1+. A quantitative 24-hour albumin which was 0.036 Gm. was obtained. This is certainly not the high-grade albuminuria seen in the classical case of nephrotic syndrome. A second factor which excludes this diagnosis is the serum cholesterol of 93 mg. per cent, a definite hypocholesterolemia. The serum albumin was 2.2 Gm. per 100 cc. and the globulin was 3.3 Gm. per 100 cc. This represents a hypoalbuminemia with the serum albumin at the "critical level." The nonprotein nitrogen, which is at the upper limit of normal; the specific gravities of 1.013 to 1.017; and the lack of cellular elements in the urinary sediment would tend to rule out other kidney disease.

With the exclusion of cardiac and renal disease as the primary etiologic factors in the production of the anasarca, we are left with liver disease as the causative factor. It was the opinion of the ward staff that this patient had portal cirrhosis. The hypoalbuminemia was the result of severe liver damage and was responsible for the generalized edema.

The patient had a long history of alcoholism, supposedly consuming a case of beer and a pint of whiskey daily for 15 years. His food intake, although said to be good, was questioned because of his malnourished appearance. There were no signs of vitamin deficiencies. The patient was thought to be icteric, which was confirmed by the elevated serum bilirubin. No liver function studies were done with the exception of the serum cholesterol, which was low, and a 3+ cephalin flocculation, the results of both of which are compatible with liver damage.

Treatment of the patient was directed primarily at the correction of the hypoalbuminemia, the hyponatremia, and hypochloremia. Serum albumin was given by the intravenous route and later supplemented by a high protein mixture by gastric drip.

The low serum sodium and chloride were believed due to the expansion and dilution of the extracellular fluid compartment. The possibility of renal salt wasting was excluded by a 24-hour balance study in which 260 mEq. of sodium and chloride were given intravenously. Only 12 mEq. of sodium and 19 mEq. of chloride were recovered in the urine. Correction of the low sodium and chloride was attempted by the limitation of fluid intake and the administration of 3 per cent sodium chloride solution intravenously, plus a high sodium chloride in the tube-feeding mixture given by gastric drip. Other supportive measures, including digitalization, were instituted. The patient did not respond to treatment and died about 56 hours after admission. The terminal events were believed to be cardiac failure and bronchopneumonia. Clinical diagnosis was portal cirrhosis with hypoalbuminemia and low salt syndrome.

**Dr. J. F. Kuzma:** The principal terminal findings in this case were those of rather recent onset of congestive heart failure as

evidenced by a very severe congestion with central anoxic necrosis of the hepatic lobules (Fig. 1). This was so severe that the patient developed evidence of jaundice, on the basis of hepatocellular necrosis, shortly before death. Periportal changes of alcoholic cirrhosis were not present, and no varices were found. The most interesting feature of the case is the explanation of the cause of the heart failure. It was found that the heart weighed 380 Gm. and was very soft, flabby, and obviously dilated. Its color was very pale throughout. The tricuspid ring was 15 cm. in circumference and the mitral ring was 12 cm. Both the pulmonary and aortic rings were 9 cm. in circumference. These valvular measurements, as well as the appearance of the chambers and outflow tract, indicate rather remarkable cardiac dilatation. The basis for this dilatation is found in the microscopic appearance of the heart muscle, which was extremely pale and showed fatty degeneration; there were also marked interstitial edema and sparse interstitial cellular infiltrations, principally lymphocytes and histiocytes. (Fig. 2). In some of the cross section fibers, a clear ring of sarcolemma was widely separated from the muscle fiber itself. (Fig. 3). This pattern of myocardial change, both grossly and microscopically, fits in with the diagnosis of nutritional disease of the heart or what is called beriberi. Perhaps a subclinical degree of cardiac failure was present in this patient for quite some time, but the sudden congestive failure brought about icterus and demise. The background of the cardiac development rests in the nutritional aberrations which this individual enjoyed for many years. The caloric intake was apparently almost exclusively limited to the carbohydrate of alcohol with which an unusually large volume of fluid was ingested. The long-continued hypoalbuminemia due to metabolic derangement of the liver was the principal cause for the existence of anasarca. The peculiar electrolyte pattern could not be accurately defined because of the death of the patient shortly after admission; however, hypervolemia may be the cause of the apparent great reduction of the electrolytes.

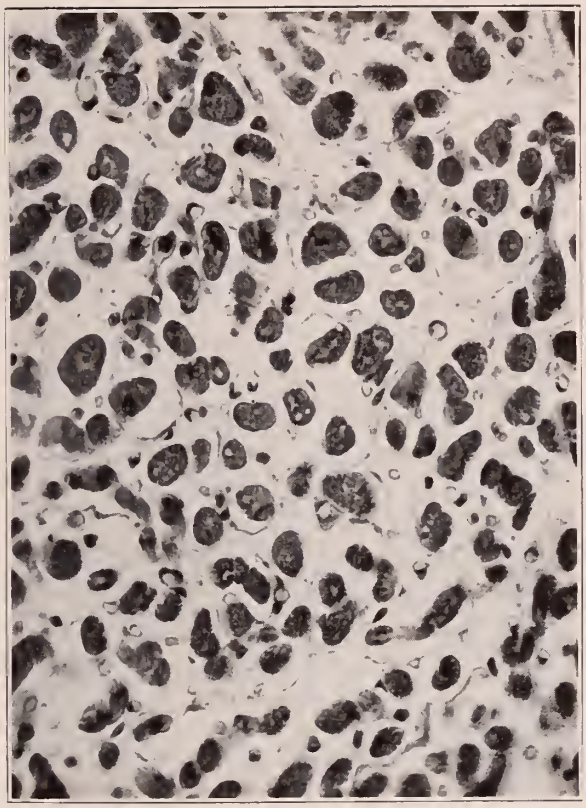

Fig. 3—Photomicrograph of myocardium showing fibers on cross section with marked separation of the fiber substance from the sarcolemma. In addition there is marked interstitial edema.

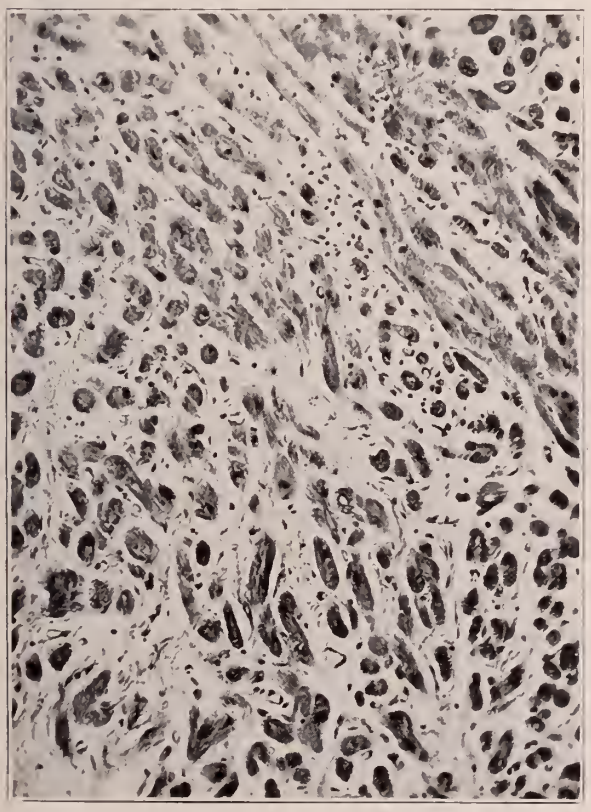

Fig. 2—Photomicrograph of heart showing an area of separation of the muscle fibers accompanied by mild interstitial reaction. The change is not specific as it may be seen in hyperthyroidism, vitamin $B_1$ deficiency, and electrolyte disturbances.

# Proceedings of the Milwaukee Academy of Medicine, February 16, 1954

## Significance of the Abnormal Carbohydrate Metabolism in Schizophrenic and Manic-Depressive Psychoses

By M. D. ALTSCHULE, M. D.*
Boston, Mass.

MANY observers have reported the common finding of abnormal glucose tolerance curves in patients with manic-depressive, involutional, and schizophrenic psychoses. A study of the nature and significance of this change, as revealed by extensive studies of intermediary carbohydrate metabolism, has been in progress at the McLean Hospital for several years;** studies have been made only on patients with schizophrenic and manic-depressive psychoses in order to avoid complicating factors introduced by advancing age.

### The Abnormal Carbohydrate Metabolism in the Psychoses

The disturbances found in carbohydrate metabolism fall into three categories: 1. abnormal utilization of carbohydrate; 2. abnormal release of carbohydrate from tissue stores; 3. insulin resistance.

Abnormal utilization of carbohydrate has been demonstrated in all patients studied after the ingestion of 100 Gm. of glucose. The glucose tolerance curve itself is abnormal in only about two-thirds of the patients, usually being normal in those who have been ill for some years; *i.e.*, 5 or 10. However, study of the breakdown products of glucose in the blood reveals additional abnormalities. Although the accumulation of pyruvic acid in the blood is not strikingly abnormal, about four-fifths of the patients show excessive rises in blood lactic acid after the ingestion of the glucose. Fragmentary studies have also revealed an abnormal rise in blood lactic acid after exercise. The next stages in the degradation of carbohydrate in the body involve citric acid and alpha-keto-glutaric acids; these accumulate abnormally in all patients.

These biochemical abnormalities are not specific for psychoses; we have found identical, but less marked changes, in all of 6 patients with multiple sclerosis. Other authors have described the same changes in epileptic children. We did not find them in a disease of the cord, progressive muscular atrophy. It is evident that this biochemical change occurs with disease of the brain, a finding that indicates that schizophrenia and manic-depressive psychosis are diseases of the brain and not merely states of mind. The pattern of this biochemical change is consistent with the effects of a block in the Krebs cycle, but of course final characterization of the disturbance must await additional study.

The abnormality in release of carbohydrate from tissue stores reveals itself in several ways. Giving phlorhizin stimulates release of glycogen from liver and muscle in response to the large loss of glucose in the urine. When this is done in normal subjects, release of glucose into the circulation keeps pace with losses through the kidney, and the blood sugar level remains constant. In psychosis, however, mobilization from the tissues is slow; and the same loss through the kidneys results in a temporary fall in blood sugar, lasting for a few hours. Mobilization of glucose from tissue stores involves two main processes: 1. rapid breakdown of hepatic glycogen and 2. a slower breakdown of muscle glycogen. These phenomena can be studied by giving epinephrine in a fixed body-weight dose. The breakdown of *hepatic* glycogen, as shown by the rapid rise in blood sugar that occurs, is normal or even excessive in cases of schizophrenic and manic-depressive psychoses. The breakdown of *muscle*

* From the Laboratory of Clinical Physiology, McLean Hospital, Waverley, and the Department of Medicine, Harvard Medical School, Boston, Massachusetts.

** Much of the work to be discussed here was done under the immediate direction of Dr. Dorothy H. Henneman.

glycogen causes a rise in blood lactic and pyruvic acids. This reaction is markedly depressed in the cases of psychoses under consideration here; the rise in blood lactic and pyruvic acids after injection of epinephrine are small or absent in most but not all cases. This biochemical abnormality also is not specific for psychosis; it occurs in a wide variety of bodily illnesses.

The third type of disturbance in carbohydrate metabolism is insulin resistance, found in about half the psychotic patients. This, too, is not specific and is found in infectious diseases, after vascular accidents (cerebral or myocardial), and in Cushing's syndrome.

It is clear that patients with schizophrenic and manic-depressive psychoses show disturbances in carbohydrate metabolism that are common in sick people, particularly those with diseases of the brain. The changes found in the psychoses cases are presumably consequences of the disease. However, in view of the fact that carbohydrate is so important for the action of the brain, these changes (except for insulin resistance, since the brain does not require insulin) perhaps constitute a factor that maintains and exacerbates the cerebral tissue.

TABLE 1—*Some Metabolic Abnormalities in Psychosis*

| | |
|---|---|
| Blood eosinophils | Low early; normal late |
| Glucose tolerance | Often impaired |
| Lactate tolerance | Usually impaired |
| Citrate tolerance | Always impaired |
| Alpha-keto-glutarate tolerance | Always impaired |
| Insulin resistance | Common |
| Glucose response to epinephrine | Normal or high |
| Lactate response to epinephrine | Low |
| Pyruvate response to epinephrine | Low |
| Carbohydrate mobilization | Retarded |
| Blood ketones | Elevated early; normal late |
| Blood cholesterol | Elevated early; normal late |
| Urine creatine | Often increased |
| Nitrogen balance | Negative early; normal late |
| Urine 17 ketosteroids | Normal or high; low if starving |
| Body water | Increased before onset; normal or high early; normal late |
| Blood sodium and potassium | Normal |
| Sweat sodium | Normal early; high late |
| Water diuresis | Normal early; retarded late |
| Blood glutathione | Usually low |
| Plasma copper | High |

## Studies on the Mechanism of the Disturbed Carbohydrate Metabolism in Psychoses

The pattern of change in blood chemistry after ingestion of glucose is different from that in diabetes; lack of insulin is therefore not a primary factor in the psychoses. The absence of any great rise in blood pyruvic acid level after ingestion of carbohydrate rules out thiamin deficiency. Adrenocortical hyperactivity is likewise probably not the primary factor; although giving ACTH frequently makes the glucose tolerance curve more abnormal in the cases of psychoses studied, it does not exacerbate all the abnormalities described here.

The mechanism of the changes observed cannot yet be defined. However, certain observations may be significant. It has been known for many years that most, but not all, patients with schizophrenic or manic-depressive psychoses have low blood glutathione levels. It is known that glutathione is important in carbohydrate metabolism, as shown by experiments on tissue slices, and also by the fact that in animals, giving substances that combine with glutathione (such as alloxan and aceto-acetic acid) causes disturbances in carbohydrate metabolism.

Intravenous injection of glutathione reverses all three of the abnormalities described here as occurring in cases of psychoses—the abnormal intermediary carbohydrate metabolism after glucose administration, the abnormally small increases in blood lactic and pyruvic acids after epinephrine administration, and the resistance to insulin are all abolished. That glutathione causes these effects by changing in some way the action of enzyme systems within the tissues is shown by the greatly increased fall in blood inorganic phosphate that occurs when glutathione is given in all the circumstances studied. An interesting finding in patients given glutathione is that psychotic patients show only half the rise in blood level found in normal subjects; this suggests that the tissues of psychotic patients are unsaturated with respect to glutathione.

It must not be concluded that the abnormalities found in the psychoses cases are due to a lack of glutathione any more than that the fact that cascara cures constipation is to be taken as evidence that constipation is due to hypocascarism. The specific role of glutathione requires clarification.

## Some Possibly Pertinent Studies on Effects of Treatment

Single electroshock or insulin treatments cause brief elevation of the blood glutathione level. After such single treatments, carbohydrate metabolism is not improved. If patients are studied a week or two after the last of such treatments, those who have gone into clinical remission now show reversal of all the biochemical abnormalities studied.

It has been known for some decades that pineal extracts cause improvement in the psychoses under consideration here; this observation has been confirmed in our laboratories. The clinical usefulness of pineal extract is nil at present since patients regularly develop refractoriness to it within one to a few weeks and may remain refractory for several years at least.

Of interest in connection with the present discussion is the fact that pineal extract causes a rise in blood glutathione level. Improvement in glucose tolerance also occurs, and the abnormal rise in blood citric acid after the ingestion of glucose is abolished. A decrease in urinary 17 ketosteroid output also occurs, indicating depression of the adrenal cortex (or anterior pituitary); but this is not correlated precisely in time with the changes in carbohydrate metabolism. At present all that can be said is that the biochemical status, at least as regards carbohydrate metabolism, is improved by pineal extracts and that these extracts also raise the blood glutathione level. Perhaps isolation of the active principle will permit clarification of these relations.

Summary

Patients with schizophrenic and manic-depressive psychoses show changes in carbohydrate metabolism commonly found in sick people, particularly those with diseases of the brain. These findings are all reversed in the psychoses patients by giving large amounts of glutathione or by inducing a lasting rise in blood glutathione level.

# *Reminder:* On Circuit Teaching Programs

If you have not already done so, sign up for the circuit teaching programs listed below which are nearest your home. Registration, $6.00, including dinner. (For the Upper Peninsula two-day session, registration of $5.00 to be paid at time of attendance. Do not send check to the State Medical Society when you register).

**June 16**
**Racine**

**CURRENT THERAPY IN THE TREATMENT OF TOXEMIAS:** Allan C. Barnes, M.D., Cleveland

**RHEUMATOID ARTHRITIS:** Edward F. Rosenberg, M.D., Chicago

**MEETING PROBLEMS OF PREMATURITY IN GENERAL PRACTICE:** James P. Conway, M.D., Milwaukee

**June 17***
**Elkhart Lake**

**June 18**
**Menominee, Mich.**

**WHAT SURGERY HAS TO OFFER IN PULMONARY DISEASE:** Joseph W. Gale, M.D., Madison

* **COUNCILOR DISTRICT MEETING.** Wives invited. $3.50 dinner charge for wives.

## *Registration Blank*

(Detach and Mail with Check, Payable to State Medical Society of Wisconsin. Mail to Box 1109, Madison, Wisconsin)

CHECK THE CLINICS YOU WILL ATTEND: $6.00 per clinic except for Menominee, Michigan. (For that meeting, $5.00 paid at time of attendance).

June 16: Racine ____

June 17: Elkhart Lake ____

June 18: Menominee, Michigan ____

# Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

## Questions and Answers Suggested by Recent Investigations in Drug Therapy

*What is the current status of isoniazid (isonicotinic acid hydrazide) in treatment of miliary and meningeal tuberculosis?* In a joint study at the New York Hospital-Cornell Medical Center and the Navajo and Hopi reservation in Arizona, Charles M. Clark (U.S.P.H.S.), DuMont F. Elmendorf, Jr., William U. Cawthon, Carl Muschenheim, and Walsh McDermott chose miliary tuberculosis as the ideal, naturally occurring situation for evaluation of isoniazid because (1) the course of this infection when untreated is generally uniform and predictably fatal; (2) interpretation of results is not complicated by the presence of large areas of necrotic lung; (3) if the number of drug-resistant parasites increases sufficiently to neutralize drug activity, there will almost invariably be a speedy relapse. They reported observations on 20 patients treated only with isoniazid during the period of study. A few had previously received other antituberculosis therapy. Diagnosis of miliary tuberculosis was based on presence of the triad of acute febrile illness, characteristic disseminated densities in chest x-rays, and demonstration of acid-fast bacilli on microscopic examination of body discharges or of Mycobacterium tuberculosis by culture. Diagnosis of meningeal tuberculosis was established by culturing Mycobacterium tuberculosis from cerebrospinal fluid or by demonstrating cerebrospinal fluid findings of nonpurulent meningitis with a low concentration of sugar (less than 35 mg. per 100 ml.) in a patient with a bacteriologically proved lesion of tuberculosis elsewhere. The 20 patients included 10 with uncomplicated miliary tuberculosis, 4 with miliary tuberculosis complicated by meningitis, and 6 with meningitis alone. Daily dosage of isoniazid was 10 mg. per kg. the first week, then 7-5 mg. per kg. regardless of the course.

Of the 14 patients with miliary tuberculosis, 12 had remissions after treatment for 3 to 7½ months. Two died, both of meningitis, during the first week of therapy. No evidence of meningitis appeared in those free from this complication when isoniazid therapy was started. Complete defervescence occurred in 7 to 49 days.

X-ray studies showed an impressive degree of clearing of disseminated densities in all 12 patients. The shortest period of therapy in which definite roentgen improvement occurred was 14 days and the longest period without favorable change was 88 days. In all of 5 patients who received isoniazid for 130 days, the densities completely disappeared. In some instances there was an associated pneumonic component; the densities disappeared completely, whereas the pneumonic component persisted, although it was regressing. There was a correlation between reversal of infectiousness, as demonstrated by smear and culture, and roentgen change.

There were no significant differences in the speed with which complete defervescence occurred or in the extremes of the shortest and longest periods of therapy required for attainment of the afebrile state. For comparison of roentgen changes, streptomycin-treated patients with miliary tuberculosis with or without meningitis were included. In 7 of the 8 streptomycin-treated patients, impressive roentgen clearing occurred by the 99th day and in 6 the densities disappeared by the 157th day of therapy. These values are essentially the same as the 88 and 130 days in the isoniazid series. All the streptomycin-treated patients were excreting tubercle bacilli when therapy was started; four months later Mycobacterium tuberculosis could be isolated from only 3. This compared with 2 of 9 for the corresponding interval in the isoniazid series.

Of the 4 patients with miliary tuberculosis and meningitis, 2 died within the first week of therapy and 1 improved dramatically. In the fourth, with only bacteriologic evidence of tuberculous meningitis, cerebrospinal fluid cultures became negative; and clinical signs of meningitis did not develop.

Of the 6 patients with tuberculous meningitis without miliary tuberculosis, 1 died during the first week of therapy. The other 5 had been previously treated with streptomycin. Two of these had been deteriorating steadily; one remained comatose despite isoniazid therapy, although cerebrospinal fluid findings improved; but the other showed striking clinical improvement after 21 days of therapy. The asymptomatic course of the 3 other patients, who had only abnormal cerebrospinal fluids at the start of isoniazid therapy, remained unaltered; but cerebrospinal fluid abnormalities gradually receded and, with one exception, normal values for the various components were all present by the 22nd week of therapy.

Comparison of the uniformly satisfactory results in the isoniazid-treated patients with uncomplicated miliary tuberculosis with results previously obtained with streptomycin permits the inference that the antituberculous activity of isoniazid in man is equivalent, and probably slightly superior, to that of streptomycin. However, no conclusion can be made as to the effectiveness of the drug in pulmonary tuberculosis in which the situation is complicated by unhealed lesions and necrotic lung.

*What ergot compound is probably safe to use in coronary disease?* The ergot derivatives are interesting in the diversity of their actions. Ergotamine, the most powerful vasoconstrictor, is also oxytocic. Ergonovine is predominantly oxytocic and practically devoid of action on vessels. The ingredients of hydergine—dihydroergocornine, dihydroergocristine and dihydroergokryptine—are predominantly sympatholytic and, like Veratrum, are capable of lowering arterial pressure without reducing, except initially, cardiac output or circulation in the liver, kidneys, or extremities. The pulse rate decrease is usually compensated by an increase in amplitude. It seems to me that coronary disease would not contraindicate the use of hydergine since this drug complex does not constrict the coronary arteries.—HARRY BECKMAN, M. D.

## BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the first half of 1954 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referral be made by the family physician; but when this is not feasible, arrangements may be made by writing to the Bureau. Forms for the purpose of referral may be obtained from the Bureau of Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify for which clinic forms are wanted.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of the fact.

| | |
|---|---|
| Rhinelander | June 2, 3 |
| Lancaster | June 10 |
| Darlington | June 11 |

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

# Maternity Hospital Standards Bring Improvement

## As It Looks to Your State Board of Health

IN THE past decade great strides have been made in reducing maternal mortality. The latest national figures show that only three states had a lower maternal death rate than Wisconsin in 1950. This is a good record and one for which the obstetric departments of Wisconsin hospitals deserve much credit.

Since 1940, communities have been confronted with a greater demand for hospital service as well as a constantly rising birth rate. Deliveries occurring in Wisconsin hospitals rose from 64.1 per cent in 1940 to 98.8 per cent in 1952; in number, from 35,091 to 87,873. Many communities were totally unprepared to meet this rising demand and the new problems it presented. However, real progress has been made through the tireless effort of doctors, nurses, hospital personnel, and many other interested individuals and agencies.

As a result of this difficult period, there was a greater awareness of the importance of obstetric department facilities and practices in further reducing maternal and infant mortality and promoting good health. Also recognized was the need for sharing and benefiting from the experience of individual hospitals. A committee representing the State Medical Society, the Wisconsin State Hospital Association, the Wisconsin Catholic Hospital Association, the Wisconsin Department of Nurses, and the Wisconsin State Board of Health therefore began working on minimum standards to be used by Wisconsin hospitals as a guide in meeting problems of facilities, equipment, and procedures. This was released in 1952 as "Rules and Regulations for Maternity Hospitals."

If such guides are to be of value to hospital staffs, they will need modification from time to time to be kept abreast of current practices. Every physician, nurse, and hospital administrator is urged to assume responsibility for pointing up changes needed to keep regulations practicable and usable. The present maternal and fetal-neonatal death studies being undertaken by medical and hospital groups may suggest needed changes. It is encouraging to see that a number of Wisconsin hospitals have taken the lead in adopting regulations for their institutions far above the minimum standards.

There is a great deal more to maternity care, however, than can ever be met through rules and regulations. The "human element" is not to be overlooked.

There is, for example, therapeutic value in making patients "feel at home" in the unfamiliar surroundings of the hospital. Personnel who take the time to help patients understand how hospital procedures and regulations relate to the protection and comfort of the mother and child will find it well worth the effort.

Practices such as "natural childbirth," "rooming-in," "self-bathing," and "father's support in the labor room" are not routine procedures to be controlled by regulations frustrating to patient and staff. The value of each practice to the individual and to the hospital must be evaluated. Letting patients do what they can for themselves, on a selective basis, has much to recommend it. It is hoped that such procedures will not be discarded on the basis of one or two unsatisfactory experiences.

The shortage of registered nurses has made it necessary to include nonprofessionals as part of the nursing team. Preparing this untrained group to provide safe maternity care involves considerable teaching and supervision by the nurse. The amount of responsibility such persons can assume varies with the individual. Regulations are useful merely as a guide.

The many demands upon the physician's time have meant that he, too, has turned over to nurses and auxiliary workers some duties heretofore restricted. This involves constant teaching and supervision by the medical staff who carry the ultimate responsibility. The rapid turnover of hospital personnel often makes this seem a never-ending task. Regulations may be helpful but can never take the place of individual supervision.

The role of the medical, nursing, and hospital staff is of prime importance if we are to reach that "irreducible minimum" in maternal and infant mortality. It means reaching far beyond minimum standards and striving for the best in maternity care in its broadest aspects.—MISS HELEN F. CALLON, *Hospital Nursing Consultant.*

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# « « « EDITORIAL » » »

## Epilepsy and the Law

The paper on epilepsy in this issue of the Wisconsin Medical Journal by Doctor Kimball stresses the genetic aspect of this disease. The State Medical Society, in the last legislature, strongly urged changes in the state law which would permit epileptics to marry and to hold a driver's license. These changes were duly enacted and are now in the statute books. We personally still believe, from the evidence at hand, they were justifiable changes and should remain as they are. However, it must always be considered that each case is an individual problem itself and, if seizures are frequent and the patient refuses adequate control, some restraint must be placed on him, either legally or by persuasion. It also seems unjustifiable to insist that every epileptic is just as normal as the general population and that he should forget the hereditary portion of his disease. The whole situation can be kept in proper focus by a realistic realization that the majority of epileptics can marry and procreate without expecting too much of a hereditary factor in their offspring. Also those individuals with epilepsy who are well under control justly deserve the privileges of driving their own motor cars, but realism also demands they should not be encouraged to do foolish things.

At the present time the Council of the State Medical Society has a committee studying all laws pertaining to epilepsy, and we shall await their final recommendations.

## Another Step in the Right Direction

When Blue Shield of Wisconsin started nine years ago, its strength came from the most logical source—large groups of employed people. Today more than 300,000 persons have Wisconsin Physicians Service protection, and all but a few thousand joined through relatively large groups.

The State Medical Society has been keenly aware of its obligation to improve Blue Shield benefits for farmers and other self-employed persons and their families.

This is now a reality. Starting May 1, all new, non-group family subscribers to Wisconsin Physicians Service have maternity benefits included with their surgical, medical, x-ray, and anesthesia protection. And Blue Cross, the hospital benefit plan, has added a maternity benefit to its non-group program. At last Wisconsin's important rural and small town elements have the opportunity to obtain Blue Shield protection equal to that held by their big city brothers.

# . . . . THE PRESIDENT'S PAGE . . . .

THIS is another "Presidential sound-off," so if you want to turn the page and get on with your scientific reading, go right ahead. A general practitioner goes to see a patient (usually in the middle of the night) who has a bellyache, is vomiting, and is sure he has an acute appendix. The physician talks to the patient at some length in order to get an accurate history; he makes a careful head to foot examination, and he checks a blood count and urinalysis. As a result of his care and skill, he concludes that the patient is right, that he does have an acute appendix and that immediate operation is the only safe course to follow. A surgeon is called in and listens to the history as elicited by the GP, examines the patient's belly, looks at the laboratory reports, and agrees to operate. An hour later the patient is back in bed, and three days later he leaves the hospital under his own power. And the fees? The surgeon gets—well let's be conservative—let's say the surgeon gets $125. But the GP—whose skill and judgment led to the original diagnosis—gets his usual house call fee plus laboratory fees.

*Question:* Is not the skill and judgment of the GP in arriving at a correct diagnosis comparable to that of the surgeon in performing the operation—at least to a greater degree than is represented by this wide divergence of fees?

But let's take another situation, one that occurs just as frequently but which I seldom hear discussed. It starts out exactly the same way. But this time the GP decides that the patient is wrong—that he does not have an acute appendix, that he does not need an operation, but that a few days of conservative medical treatment will fix him up. His judgment proves correct, and in a few days the patient is back on the job again, good as new. Now the knowledge, skill, judgment, and responsibility required to say that a patient does *not* have an acute appendix and does *not* need surgery is certainly no less than that required to say that he does. So we come to this:

*Question:* How should the fee for what the GP did in this case compare with what many people maintain he was entitled to in the other case?

*Answer:* That is a good question!

And here are some more thoughts on the subject of fees: I often wonder if our patients are getting the full financial benefit that improved methods of treatment should provide. Most cases of scarlet fever, pneumonia, urinary tract infections, and a host of other conditions certainly require less medical management and consequently cost less than they formerly did. But an appendix is still an appendix, and a hernia is still a hernia, so far as the cash outlay is concerned, in spite of the fact that improved operative procedures, improved anesthesia, and early ambulation practices have combined to bring about an appreciable simplification of the whole process for both surgeon and patient. I realize full well that it requires just as much skill and judgment to repair a hernia today as it did 25 years ago and that it is skill and judgment rather than time that surgeons are paid for. But isn't it just possible that the simplicity of the whole procedure should be given some consideration?

Not that they need it, but in defense of surgeons let me say this: We frequently hear the remark that, after all, the removal of an appendix is a pretty simple job and that one need not be a diplomate of the American Board to do it well. But suppose the operator opens a belly, expecting to find a simple appendix, but instead finds a gangrenous Meckel's diverticulum which will require resection of the ileum. Is his skill—adequate though it may be to remove an appendix—surely adequate to do an end to end anastomosis of the ileum? In other words, anyone who opens a belly should have a versatility of skills adequate to meet any situation that may arise. But that still does not alter the fact that a great many surgical procedures really are pretty simple affairs—until the bill comes in.

Just one more thought on the question of fees: The A.M.A., the A.C.S., and the A.A.G.P. are all officially and vociferously opposed to the dishonorable practice of fee splitting, even though there has been some interalphabetical argument as to which group is the most responsible for its perpetration. It seems to some of the innocent bystanders that the temptation to split fees might be a little less if there was a little less discrepancy between surgical fees. But in any event, there is one, and only one, real and simple cure for the evil. It has never failed yet but unfortunately has not been tried on a wide enough scale. Just don't do it. It's as simple as that; just don't do it.

H. Kent Tenney M.D.

# Society Proceedings

## Brown–Kewaunee–Door

The Brown–Kewaunee–Door County Medical Society met at the Elks Club, Green Bay, on March 11. The members heard *Dr. Tibor J. Greenwalt*, Milwaukee, speak on "Prenatal and Postnatal Rh Problems."

On Thursday, April 8, the doctors again met at the Elks Club, Green Bay, to hear a Milwaukee urologist, *Dr. James W. Sargent*, discuss "Hematuria."

## Fond du Lac

Dr. Stuart C. Runkle of Fond du Lac spoke to the members of the Fond du Lac County Medical Society on March 25 at the 101 Club, Fond du Lac. Doctor Runkle is a psychiatrist at the Waupun State Prison and is consulting child psychiatrist under the Fond du Lac city health program. He spoke on "The Problem of Sexual Deviates."

## Juneau

Members of the Juneau County Medical Society met at the residence of *Dr. J. S. Hess, Jr.* in Mauston on March 8. *Dr. Vernon M. Griffin*, Mauston, summarized papers on the surgical postgraduate course given at the University of Wisconsin Medical School in February.

## Kenosha

Forty-one members of the Kenosha County Medical Society met on April 1 at the Oage Thomsen's Restaurant, Kenosha, to hear *Dr. J. E. Conley*, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee. Doctor Conley spoke on the "Present Trends in Vascular Diseases."

## Marinette–Florence

*Dr. Raymond H. Quade*, neurological surgeon from Neenah, spoke to members of the Marinette–Florence County Medical Society at the St. Joseph-Lloyd Hospital, Marinette, on March 17. Doctor Quade spoke on "Head Injuries."

## Richland

The March meeting of the Richland County Medical Society was held at the home of *Dr. D. J. Taft*, Richland Center. *Dr. Carl S. Harper*, Madison, spoke to the group on "Vaginal Hysterectomy."

*Dr. Robert Parkin*, Madison, was the speaker at the meeting held April 1. *Dr. George Parke* was the sponsor of the meeting at the V.F.W. Club. Doctor Parkin spoke on the "Use of Radio and Television in Medical Radio Programs."

## Trempealeau–Jackson–Buffalo

On Tuesday, March 23, members of the Trempealeau–Jackson–Buffalo County Medical Society and their wives met at the Eagle Hotel, Fountain City, for a dinner meeting. Following dinner, a scientific program on the use of intra-articular Hydrocortone was given.

## Walworth

Twelve members of the Walworth County Medical Society and their wives met at the Colonial Hotel, Delavan, on March 11 for a dinner meeting. *Dr. George Thomas*, orthopedic surgeon from Janesville, spoke on "Lesions of the Low Back," and members of the county society added to the talk with a round-table discussion on the subject.

A study club which would meet once a month to discuss a scientific subject of interest to the members of the Walworth County Medical Society was established. The first meeting was held at *Dr. R. A. Moses'* home in Delavan on March 24. Doctor Moses was the discussant at the first meeting.

## Winnebago

The Winnebago County Medical Society met at the Athearn Hotel, Oshkosh, for its regular monthly dinner Thursday, April 1. *Dr. Henry M. Suckle*, Madison neurosurgeon, spoke on "Intercranial Anuerysma."

## Waukesha

Thirty members of the Waukesha County Medical Society met at Scherer's Restaurant in Pewaukee on March 3. *Dr. I. I. Cowan*, director of the Isotope Laboratory, Marquette University School of Medicine, spoke on "Radioactive Isotopes in Clinical Medicine."

## American Academy of General Practice

The sixth annual scientific assembly of the American Academy of General Practice was held from March 22 to March 25 in Cleveland, Ohio. More than 100 physicians from Wisconsin attended the session.

*Dr. William B. Hildebrand*, Menasha, was installed as president of the Academy. Among the lecturers at the scientific sessions were *Dr. William S. Middleton*, dean of the University of Wisconsin Medical School, and Sir Alexander Fleming, the man who discovered penicillin.

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## National Gastroenterological Association

The National Gastroenterological Association held its central regional meeting on March 28 at the Hotel Schroeder, Milwaukee. There were about 250 physicians attending. The program consisted of business sessions in the morning and scientific talks in the afternoon. The central region includes Wisconsin, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, and Ohio.

Speakers included *Dr. Robert T. McCarty*, Milwaukee, associate professor of surgery at the Marquette University School of Medicine; *Dr. Carl W. Eberbach*, Milwaukee, clinical professor of surgery at Marquette; *Dr. Karver L. Puestow*, Madison, professor of medicine at the University of Wisconsin Medical School; *Dr. Gerhard D. Straus*, Milwaukee, clinical professor and director of the division of otolaryngology at Marquette; *Drs. H. B. Benjamin* and *Marvin Wagner*, Milwaukee, of the anatomy department of Marquette; Dr. James A. Ferguson, Grand Rapids, Michigan; Dr. J. Arnold Bargen, Rochester, Minnesota, professor of medicine at the University of Minnesota Medical School; and Dr. Philip Thorek of Chicago, associate professor of surgery at the University of Illinois College of Medicine.

## Wisconsin Surgical Club

Nineteen members and guests of the Wisconsin Surgical Club left Chicago on February 21 for New York, where a week was spent in visiting some of the principal surgical centers of that city. Hospitals visited were New York University–Bellevue Medical Center; Memorial Center, which included the Sloan-Kettering Research Laboratories; Presbyterian Hospital; and New York Hospital.

The following members of the club visited New York on the tour: *Drs. T. J. Snodgrass*, Janesville; *Arnold S. Jackson*, Madison; *Erwin Schmidt*, Madison; *Victor F. Marshall*, Appleton; *Russell M. Kurten*, Racine; *S. Gundersen*, La Crosse; *S. E. Gavin*, Fond du Lac; *Carl Eberbach*, Milwaukee; *Conde F. Conroy*, Milwaukee; *F. G. Connell*, Oshkosh; *Peter Midelfart*, Eau Claire; *Warner Bump*, Rhinelander; and *Frank Weeks*, Ashland.

Dr. Morrison Schroeder, Milwaukee; *Dr. J. A. Killins*, Green Bay; and *Dr. J. R. Steeper*, Madison, were guests of the Wisconsin Surgical Club. *Dr. Louis D. Graber* of Oshkosh accompanied the group as the guest of Dr. F. G. Connell. Dr. Arthur S. Moody, Dunadin, New Zealand, was the guest of Dr. Frank Weeks. Doctor Moody was on his way from New Zealand to London on a trip around the world.

# News Items and Personals

## Doctor Heath of Juneau Has Retired

*Dr. H. J. Heath* of Juneau was forced to retire from practice following an eye hemorrhage on March 22 which rendered him almost totally blind. Doctor Heath was a physician and surgeon in Juneau for 27 years. He was graduated from Rush Medical School of the University of Chicago in 1927. He served his internship in the West Suburban Hospital, Oak Park, Illinois.

For many years he has been the attending physician at Dodge County institutions and had served his community in previous years as health officer for the city of Juneau and neighboring townships and as a director of the Juneau Board of Education.

## Dr. Anthony Voskuil Honored on Anniversary

The entire community of Cedar Grove joined to make the birthday of *Dr. A. Voskuil* a memorable one. Congratulatory messages were sent to the doctor from nearby and distant places. Having practiced at Cedar Grove continuously since 1909, Doctor Voskuil has become a vital part of the village and the surrounding area. In 1942 the community honored Doctor Voskuil and the late Dr. L. A. Van Altena in recognition of their long terms of service at Cedar Grove.

## Dr. J. P. Springer Heads Hospital Staff

*Dr. Joseph P. Springer*, Elmwood, was elected president of the Memorial Hospital staff, Menomonie, at its March meeting. *Dr. S. R. Lee*, Menomonie, succeeds *Dr. A. A. Drescher*, Menomonie, as secretary, while *Dr. E. F. Hill*, Spring Valley, is the new vice-president succeeding *Dr. F. D. Cook*, Menomonie. *Dr. A. E. McMahon*, Menomonie, is the former president of the hospital staff.

## Dr. Marvin E. Royce Returns from Korea

In December 1952, *Dr. Marvin E. Royce* closed his office in Mayville to serve as a medical officer in the Army. He recently returned from Korea and, after a vacation, is planning to return to his practice.

## Wausau Physician Speaks

*Dr. T. C. Burr, Jr.*, Wausau, spoke at the vocational school in Wausau on March 16 on "Health and Diet Past 50." This was the first in a series of talks on "Planning for Later Years." Doctor Burr, a 1950 graduate of the University of Indiana School of Medicine, is associated with *Drs. J. M.* and *D. J. Freeman* of Wausau.

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## Doctor Weisse Attends Meeting

*Dr. H. A. Weisse*, Plymouth, attended the Interim Meeting of District 6 of the American Academy of Obstetrics and Gynecology, of which he is a Fellow. The meeting was held in Chicago in early March. Scientific sessions were conducted by the professors of obstetrics and gynecology from several midwestern university medical schools.

## Dr. R. E. Terry Joins Hazel Green Clinic

*Dr. R. E. Terry*, Cuba City, has joined the staff of the Hazel Green Clinic. He has also been appointed to the staff of Mercy and Finley hospitals in Dubuque, Iowa. Doctor Terry, who has limited his practice for over a year due to a virus infection, will resume full practice.

## Pan-American Congress Is Attended by Dr. J. P. Harkins

While in Mexico on a vacation, *Dr. J. P. Harkins*, Portage, attended the Pan–American Congress of Otorhinolaryngology and Bronchoesophagology held at the new University of Mexico at University City. Papers at the medical sessions were read in four languages—English, Spanish, French, and Portuguese. Selective translations enabled all attending members to hear the talks in any of the four languages through earphones. The Congress was attended by doctors from Latin America, Canada, the United States, and Europe.

## Doctor Bartos Speaks to Group in Waukesha

Forty-five members of the Golden Age Club met at the Youth Center, Waukesha, on March 15 and heard *Dr. Joseph A. Bartos*, Waukesha physician, speak. Doctor Bartos stressed the need for physical checkups and discussed several diseases common in people over 60.

# THIRD AND TWELFTH DISTRICTS NEWS

## Doctor Harvey Honored for 42 Years of Service in Footville

A grateful village turned out *en masse* on March 15 to honor *Dr. J. R. Harvey* for his 42 years of devoted, friendly service to the community of Footville. During the brief ceremonies which followed a dinner, Doctor Harvey was presented with an engraved silver plaque on behalf of the State Medical Society by *Dr. Harry Kasten*, Beloit. The plaque bore the inscription: "Honored: James A. Harvey, M.D., Footville, Wisconsin, for his devoted service to medicine and public health. Presented on March 15, 1954, by the State Medical Society of Wisconsin."

Physicians from nearby towns attending the dinner were *Dr. V. W. Koch*, Janesville, Dr. Thomas Dorman, Janesville, and *Dr. John Holmes*, Milton Junction; E. E. Dennison, a dentist from Evansville, also attended. Doctor Koch traced Doctor Harvey's career from medical school, where he was in the first

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class to graduate from Marquette University School of Medicine, through his internship at Milwaukee County Hospital, his captaincy in the Army in World War I, and up to the present.

## Sauk

The Sauk County Medical Society met on March 9 at the Warren Hotel, Baraboo. Fifteen members of the society heard *Dr. John W. Harris,* professor and chairman of the department of obstetrics and gynecology, University of Wisconsin Medical School, speak on "Choice of Treatment for Prolapse Uterus."

## Doctor McIllece Retires from Private Practice

*Dr. Patricia McIllece,* who has been engaged in the practice of pediatrics in Madison since January, 1951, has announced her retirement from private practice on April 1. Doctor McIllece will be associated with the State Bureau of Handicapped Children on a part-time basis beginning June 1.

## Doctor Reese Attends Chicago Meeting

*Dr. Hans H. Reese,* Madison, professor of neuropsychiatry at the University of Wisconsin, attended a meeting of the American College of Physicians which was held in Chicago in early April. During the scientific sessions, Doctor Reese participated in a clinicopathological conference.

## Three Madison Doctors Speak in Milwaukee

At the spring meeting of the Wisconsin Trudeau Society in Milwaukee on April 1, three Madison physicians discussed tuberculosis treatment trends. The three participants were *Drs. John Mendenhall,* consultant to the Veterans Administration Hospital, *Helen A. Dickie* and *Joseph W. Gale,* both of Wisconsin General Hospital. Doctors Dickie and Gale participated in a symposium on recent advances in treatment of pulmonary tuberculosis.

## Doctor Garvey Heads Columbia Staff

*Dr. John L. Garvey* was re-elected chief of staff of Columbia Hospital, Milwaukee, by the hospital's board of directors on April 1. Also re-elected were *Dr. Elwood W. Mason,* chief of the medical division; *Dr. Forrester Raine,* chief of the surgery division; and *Dr. F. Jackson Stoddard,* chief of the department of obstetrics and gynecology. All the physicians are from Milwaukee.

## Doctor Sargent Is Diplomate

In March *Dr. James W. Sargent,* Milwaukee, was certified by the American Board of Urology. Doctor Sargent was graduated from the University of Michigan Medical School in 1943. He interned at the U. S. Naval Hospital, Bethesda, Maryland, and served his residency at the Mayo Foundation, Rochester, Minnesota. He is a clinical instructor at

Marquette University School of Medicine and is a member of the Wisconsin Urological Society.

## Dr. J. P. Wild Completes Postgraduate Course

*Dr. J. P. Wild,* Milwaukee, recently completed a course in Endaural Surgery at the Postgraduate Medical School of New York University–Bellevue Medical Center. Endaural Surgery was a full-time course of 10 days' duration dealing with the anatomy of the temporal bone and the technics of endaural surgery in chronic mastoiditis. The course was given under the direction of Dr. John F. Daly, professor and chairman of the Department of Otorhinolaryngology.

Doctor Wild is a staff member of the Milwaukee County Hospital, St. Luke's Hospital, St. Michael Hospital, and St. Joseph's Hospital.

Postgraduate Medical School is part of the newly developed Medical Center of New York University which proposes to serve the community and the nation through an integrated program of medical research, training, and care.

## Milwaukee Hospital Has Staff Elections

*Dr. Roland S. Cron,* obstetrician and gynecologist, was re-elected chief of staff of Milwaukee Hospital at a staff meeting on March 11. *Dr. Ralph P. Sproule,* eye, ear, nose, and throat specialist, was re-elected vice-chairman of the staff. *Dr. Einar R. Daniels,* an internist, was re-elected secretary-treasurer. *Dr. Carl W. Eberbach,* a surgeon, was re-elected to the staff executive committee.

## Milwaukee Neuro-Psychiatric Society

The Milwaukee Neuro-Psychiatric Society met on March 17 at the University Club, Milwaukee. Presentations made were "Treatment of Depression," by *Dr. Samuel B. Black,* "The Emotional Picture of Children with Ulcerative Colitis," by *Dr. Bernhard Kaufman,* "Therapeutic Activities at the Hospital for Mental Diseases," by *Dr. Paul J. Lawler,* and "Group Method of Psychotherapy," by *Dr. Ervin Teplin.* The four physicians are all from Milwaukee.

## SOCIETY RECORDS

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Stanley Schilling, Monroe Clinic, Monroe.
R. L. Hansen, Colby.
C. W. Horswill, River Falls Clinic, River Falls.
J. B. Weissler, 1011 North Eighth Street, Sheboygan.
Halbert Gulbrandsen,** 1136 Forest, Denver, Colorado.
Everette Gustafson, 1707 Main Street, La Crosse.
Thorsten Smith, 615 Rand Street, Chippewa Falls.
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Changes of Address

R. E. Terry, Cuba City, to Hazel Green Clinic, Hazel Green.
D. R. Peterson, Black River Falls, to Independence.
E. H. Federman, Waukesha, to Route 2, Montello.
D. H. Bruns, Camarillo, California, to 2500 East Van Buren Street, Phoenix, Arizona.
C. T. Ziegler,* Milwaukee, to 538 Wheaton Road, Fort Sam Houston, Texas.
W. F. Merdinger, Boston, Massachusetts, to 3821 North Bartlett Avenue, Milwaukee.
H. R. Duffy,* El Toro, California, to First Marine Air Wing, % Fleet Post Office, San Francisco, California.
L. J. Kreissl,* Milwaukee, to Pathology Department, U. S. Naval Hospital, Oakland, California.
O. S. Orth, Middleton, to 1300 University Avenue, Madison.
Margaret A. Schaefer, La Crosse, to 771 Havana Street, Aurora, Colorado.
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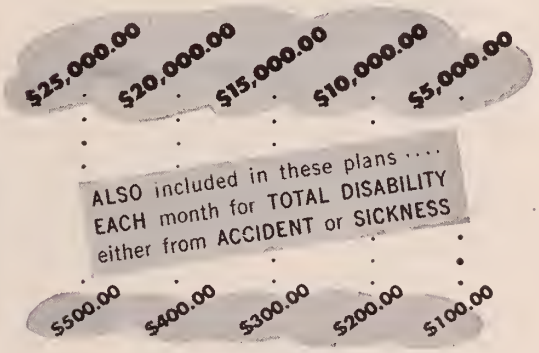


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P. S. Pierson, Great Lakes, Illinois, to 801 East Ravine Lane, Milwaukee.

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* Military service.
** Reinstated member.

## DEATHS

**Dr. H. S. Roby**, 81, died Sunday, March 28, while attending church in Milwaukee. He was born on August 18, 1872, in Evansville, Wisconsin, and received his early education in Milwaukee schools.

In 1904 Doctor Roby was graduated from Northwestern University Medical School. He completed his internship at Cook County Hospital, Chicago. Doctor Roby practiced in Milwaukee from 1907 until his retirement in 1951. For several years he was chief of staff of St. Luke's Hospital.

Doctor Roby was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Surviving are his widow, Winifred; two daughters, Mrs. Ralph G. Abbott, McKinney, Texas, and Mrs. John E. McManus, La Mesa, California; two sons, Harlow S., Jr., Madison, and Clark D., Milwaukee; and a brother, Harrison G., Washington, D. C.

**Dr. Wesley E. Froggatt** of Cross Plains died at his home on March 31. He was born in 1870 and was 84 at the time of his death.

Doctor Froggatt was graduated from Detroit College of Medicine, Detroit, Michigan, in 1895. He interned at St. Mary's Hospital, Detroit. A member of the Fifty-Year Club of the State Medical Society, he practiced in Cross Plains for 53 years.

Doctor Froggatt was a member of the Dane County Medical Society, the State Medical Society, and the American Medical Association.

**Dr. Louis A. Weisfeldt**, 44, widely known Milwaukee surgeon, died Saturday, April 3, at his home in Milwaukee. He was born November 16, 1909, in Milwaukee; and in 1935 he was graduated from Rush Medical College of the University of Chicago.

Doctor Weisfeldt was a member of the surgery staff of Mount Sinai Hospital, where he had served both his internship and his residency. He was also on the surgical staff of Misericordia Hospital and on the executive board of Doctors Hospital. He was surgical head of the Weisfeldt, Rothman & Weisfeldt Clinic.

He was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association. He was a Fellow of the College of Industrial Surgeons and the International College of Surgery. He was active in the medical services of the Milwaukee civil defense and disaster committee, a member of the Industrial Medical Association and the United States Committee of the World Medical Association.

Survivors are his widow, Geraldine; a daughter, Maxine, at home; his mother, Mrs. Dora Weisfeldt; two brothers, Simon Weisfeldt, M.D., and Harry J.; and a sister, Mrs. Rebecca Peltin, all of Milwaukee.

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## Blue Shield and Blue Cross Split on Reinsurance

Nationally, Blue Shield and Blue Cross do not see eye to eye on the government's proposal for reinsurance as a means of "encouraging and stimulating the expansion of voluntary health programs." This was made quite clear at the annual meeting of Blue Shield and Blue Cross plans held in New York City from April 4 to 8.

Wisconsin Physicians Service was represented by Dr. E. M. Dessloch, Prairie du Chien, who took his place as a member of the National Blue Shield Commission representing the north central states, and Dr. Richard Foregger, Milwaukee.

Blue Shield takes the position that the President's reinsurance proposal "may well be unnecessary for Blue Shield plans." Blue Cross says it is a "step in the right direction."

The differing viewpoints apparently stem from a fundamental difference in philosophy and outlook. Blue Cross is tied closely to the American Hospital Association, which favors reinsurance. Many of the nation's hospitals are for the most part public institutions, long accustomed to direct or indirect governmental assistance, whether local, state, or federal. Some Blue Cross plans with open-end obligations for "service" benefits on room and board charges think they see in reinsurance a chance to maintain a more stable financial equilibrium. Most all Blue Cross plans think it's time to quit opposing government in the health care field since this is considered to be a "favorable" administration, and Blue Cross leaders "see nothing dangerous" in the reinsurance proposal.

Blue Shield plans, on the other hand, are creatures of the medical profession and, as such, reflect the free enterprise "do it better and cheaper locally" attitude that has brought about such phenomenal growth in voluntary medical-surgical plans under medical and private carrier sponsorship. The medical profession is inclined to heed the advice of insurance actuaries and business consultants who say that reinsurance is *not insurance* against excess losses but merely a long-term method of financing heavy losses. Under reinsurance, losses are made up by the participating plan in full, plus charges for financing. In other words, reinsurance tends to raise rather than lower the cost of operating a health insurance business. Operated on any other basis, governmental reinsurance becomes subsidy; and subsidy means government control of one kind or another.

A wide variety of experiments in new fields of coverage are currently under way by Blue Shield plans across the nation. These experiments involve thousands of people in areas of non-group coverage, rural enrollment, care of the aged, coverage for the indigent, and catastrophic protection. They have not required reinsurance. But it is available from private sources if it is desired. This is certainly true in Wisconsin.

Blue Shield plans and the medical profession itself have no quarrel with government doing its share in the appropriate role. But there is no evidence that reinsurance from government sources would do anything that couldn't be done equally well or better through private means. Blue Shield plans, in particular, can see no logic in abandoning a fundamental concept of good business and free enterprise on the theory that now is a good time to snuggle up with the Federal Government.

Blue Cross leaders at the New York meeting made a determined effort to change Blue Shield opinion by appearing before the reference committee handling the reinsurance matter. To the extent that Blue Shield did not flatly oppose reinsurance, they were successful. But, in general, Blue Shield stood firmly on its own two feet.

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Esophageal Surgery, One Week, June 14
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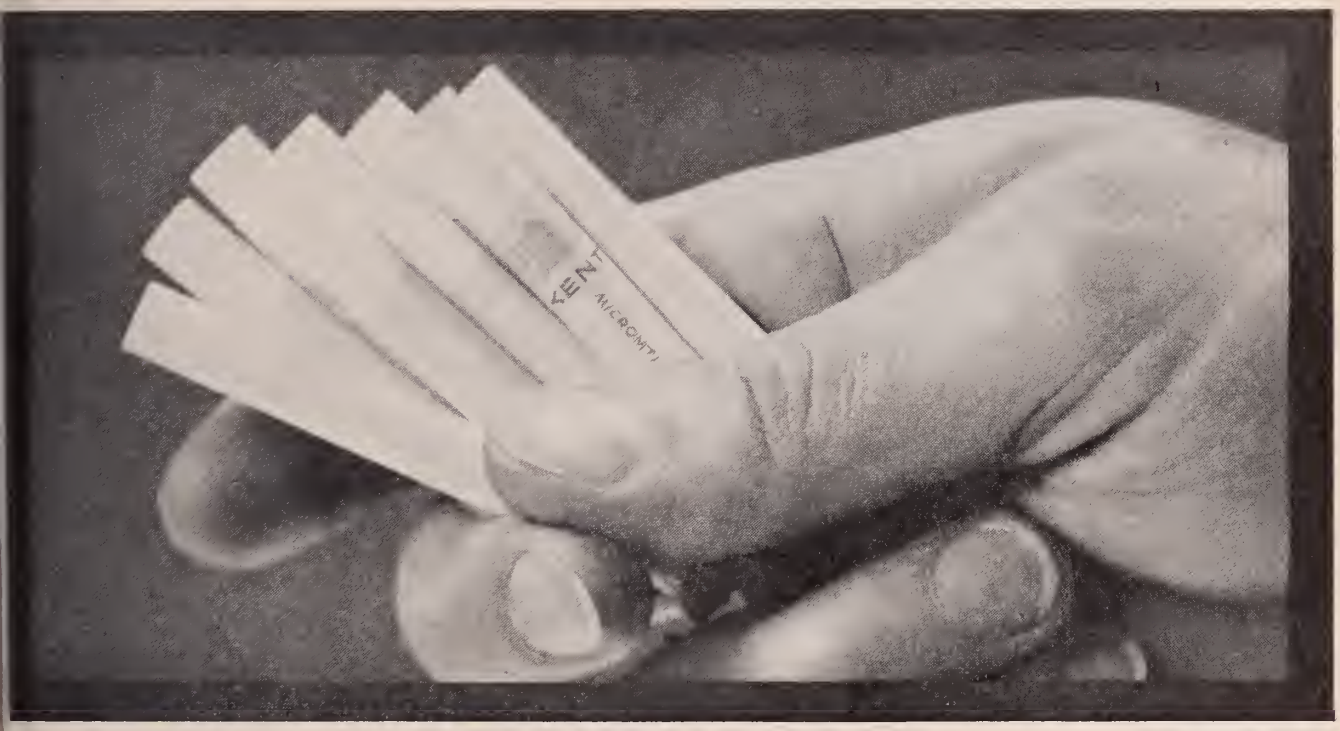


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# Anesthesia For the Patient With Cardiac Disease*

By JOHN W. PENDER, M. D.**
Rochester, Minn.

THE patient with a diseased heart is a poorer risk for anesthesia and operation than a similar patient with a normal heart, but the patient with well-compensated heart disease may represent a good risk for operation. Just how much the risk is increased by cardiac disease depends on the character of the disease and its effect on the functional status of the heart. Before anesthesia is administered to a patient with heart disease, three steps should be taken: (1) diagnose the pathologic changes in the heart; (2) evaluate the impairment of cardiac function; and (3) plan the anesthesia and operation to promote the greatest safety for the patient.

## Diagnosis

A preoperative consultation with an internist is invaluable; but accurate, detailed preoperative diagnosis of the cardiac lesion or lesions is not always possible even for the experienced cardiologist with all diagnostic aids available. Such recently developed special laboratory aids as cardiac catheterization are not generally available for diagnosis in special cases. Not all anesthesiologists are fortunate enough to have a cardiologist appraise each patient who has cardiac disease but must examine the patient themselves and confirm the impressions of the surgeon or the general practitioner. Not all patients who have heart disease can be operated on at established cardiac centers, and each anesthesiologist is bound to see that as accurate and as detailed a diagnosis of the cardiac disease as possible be made in each patient before he administers the anesthesia. Only a few of the classes of cardiac diseases can be mentioned here, and the problems each usually presents to the anesthesiologist can be discussed only briefly.

*Hypertension.* Elevation of blood pressure in itself is not a serious complication in the patient who is to be anesthetized. Rather, the problem is the pathologic changes in the heart and blood vessels which so often are associated with hypertension. As a general rule, elevated blood pressure is less stable than normal pressure; and hypotension is more likely to occur during operation on a patient with preoperative hypertension than during operation on a patient with normal preoperative pressure.

What constitutes a safe minimal blood pressure is still unsettled, but it is undoubtedly a relative figure. Whereas a systolic blood pressure of 70 mm. of mercury might be considered safe in a patient with a usual blood pressure of 120 mm. of mercury systolic and 80 mm. diastolic and with normal blood vessels, a systolic pressure of 120 mm. might be dangerous in a patient who has a usual blood pressure of 250/150 and whose blood vessels have lumens that are markedly narrowed. If it is uncertain what the minimal safe blood pressure is in the conscious patient, it is even more uncertain in the anesthetized patient since the effects of most of the general anesthetic agents on the cardiovascular system are so poorly understood. Even though most such agents may cause a dilatation of normal blood vessels, the extent of their action on structurally damaged vessels cannot be predicted.

At times the effect of general anesthesia on the blood pressure of a patient with mild hypertension may be of diagnostic significance. If such a patient usually has a waking systolic blood pressure of 160 to 180: if, after preanesthetic medication, he comes to the operating room with a systolic pressure of 145; and if, after the induction of light surgical anesthesia, the systolic pres-

* Presented at the One Hundred and Twelfth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 6, 1953

** Section of Anesthesiology and Intravenous Therapy, Mayo Clinic.

sure remains about 130 throughout an uncomplicated operation of average duration, it is fairly good evidence that the arteries of the patient are still structurally and functionally in good condition.

*Arteriosclerosis.* As has been intimated, the condition of the arteries is much more important in determining the anesthetic risk than is the blood-pressure reading. Small arteries with a structurally narrowed lumen require a high pressure to conduct a normal blood flow to the tissues, and they reduce the ability to compensate for stress and decrease in blood pressure. The condition of the vessels through which the oxygen supply to such vital organs as the brain, myocardium, and kidney must pass is of great importance in determining how well the stress of anesthesia and operation can be tolerated by the individual patient. Unfortunately, we have no accurate or objective means of observing or measuring the condition of these vessels *in vivo.*

Excessive hypertension, as occurs occasionally from undetermined causes during anesthesia, and even the mild hypertension which frequently follows the administration of certain anesthetic agents or drugs commonly used with anesthetic agents, may be detrimental in the patient with severe arteriosclerosis. Although spontaneous rupture of blood vessels occurs only rarely during anesthesia, it seems reasonable to believe that uncontrolled high blood pressure is more likely to rupture a vessel whose wall has been weakened by sclerotic plaques than it is to rupture a normal vessel. When the cause of the rise in pressure cannot be determined and the rise is thought to be dangerous, occasionally I slowly administer 1 or 2 cc. of 10 per cent solution of sodium nitrite intravenously in order to reduce the blood pressure to a relatively safe level. Hexamethonium may also be used to reduce blood pressure.

*Disease of the Coronary Arteries.* Quite frequently, anesthesia must be administered to patients who have had disabling angina pectoris and coronary occlusions. In my experience, such patients usually withstand limited anesthesia and operation well. This result is probably attributable to the fact that the anesthesiologist takes extraordinary care to maintain homeostasis in the patient and to treat early any deviation from the normal. An adequate oxygen supply to the myocardium through narrowed coronary arteries can best be insured by keeping the lungs well ventilated with oxygen-rich gas mixtures and maintaining a normal blood pressure in the proximal aorta. The devices and technics used to accomplish these two objectives vary widely according to the circumstances and the previous experiences of the anesthesiologist.

*Arrhythmias.* Very few of us would want to induce surgical anesthesia in a patient who is having an attack of paroxysmal auricular or ventricular tachycardia if the operation could reasonably be postponed until the arrhythmia is controlled. Neither would we care to anesthetize a patient who has a heart block and a bradycardia severe enough to reduce cardiac output seriously. On the other hand, there are more common cardiac arrhythmias which do not significantly decrease the capacity of the heart to do its work and which are not usually considered absolute contraindications to the use of anesthesia. Many patients have premature ventricular contractions at irregular intervals, frequently from undetermined causes. When fully anesthetized, these patients may maintain a regular cardiac rhythm, only to have the arrhythmia return during recovery. In my experience, this has happened more frequently when ethyl ether was the anesthetic agent used. If cyclopropane is to be used for a patient already having premature ventricular contractions, the pulse should be observed more carefully than usual to ascertain whether the cyclopropane has no effect or increases the incidence of the premature contractions. A diseased heart cannot tolerate arrhythmia as well as a heart with a good reserve.

When associated with a reasonably normal heart rate, persistent auricular fibrillation seems to decrease only slightly the capacity of the heart to perform its function. Patients with auricular fibrillation associated with mitral stenosis, if adequately digitalized, seem to have less tachycardia during mitral commissurotomy than patients who maintain a sinus rhythm; but this is not true in every case.

*Arteriovenous Shunts of the Heart and Great Vessels.* A fistula through which the flow is from the left side to the right side of the heart seems to be less disabling in general than one through which the flow is in the reverse direction, because there is no associated cyanosis. The left-to-right shunt increases the work of the heart in propor-

tion to the percentage of the cardiac output which passes through the shunt. In some patients with large shunts, such as from a large patent ductus arteriosus, the flow through the shunt may amount to as much as 20 to 75 per cent of the cardiac output. This increases the work of the heart in sending blood to the tissues and hence decreases the cardiac reserve and may lead to decompensation. Both of these are serious disabilities in a patient who is to be anesthetized.

Right-to-left shunts, such as may occur in patients with large interauricular septal defects and tetralogy of Fallot or related congenital defects, result in a decrease in the oxygen saturation of the arterial blood. As compensation for this desaturation, a polycythemia is developed. However, the polycythemia, with increase in hematocrit reading, increases the viscosity of the blood so that it flows more slowly through the small peripheral vessels and hence, it is said, there is increased danger of thrombus formation.

Patients with chronic cyanotic heart disease seem to develop a tolerance to lowered oxygen tension in arterial blood since some can tolerate an oxygen saturation as low as 50 to 60 per cent for a half hour or longer during anesthesia and operation without postoperative sequelae attributable to hypoxia. I would not expect the normal individual to withstand such degrees of hypoxia so well.

The anesthesiologist sometimes feels frustrated when patients with right-to-left shunts become progressively cyanotic as the operation proceeds, in spite of adequate ventilation of the lungs with oxygen. The increased cyanosis is usually on a cardiac basis, owing to increase in the shunt or decrease in cardiac efficiency; hence, while high concentration of oxygen in the alveoli helps to reduce cyanosis, it may not help enough, regardless of the minute volume of respiration maintained. Usually, correction of the defect is the only measure that will materially help to raise the arterial oxygen saturation; and the quicker this is accomplished, the safer the patient will be.

*Valvular Defects.* The adequacy of cardiac reserve is the critical problem. The intensity of heart murmurs is not a criterion of cardiac function. Regardless of whether the valvular defect is characterized by stenosis or regurgitation, it acts as an obstruction to the flow of blood and hence necessitates increased work by the heart. Early, when the obstruction is small, the heart may be able to overcome it with only a slight loss in cardiac reserve and ability to accommodate to the physiologic changes caused by anesthesia and operation. Eventually, if the obstruction increases, the heart may be unable to overcome it; and decompensation will occur.

Although valvular stenosis and valvular insufficiency have the common property of obstructing blood flow through the heart, it is important that the two be accurately differentiated if possible. At present most "pure" valvular stenoses are amenable to surgical correction, while valvular insufficiency, or regurgitation, is not. If valvular insufficiency is incorrectly diagnosed valvular stenosis and the error is not discovered until the defect is palpated during operation, the prognosis is poor if the patient has a low cardiac reserve. When the patient has had difficulty getting along under the best of circumstances, he may not be able to withstand an extensive operation which failed to remove his valvular defect.

When a stenosis on the right side of the heart, such as pulmonary valvular stenosis, is corrected surgically, the patient usually becomes a much better risk almost immediately, owing to the increased flow of blood by the same cardiac effort. When a stenosis on the left side, such as mitral-valve stenosis, is corrected surgically, very little immediate change in the patient is noted except perhaps that he may then stop "going downhill." This delay in benefit is explainable by the fact that over a period of time a hypertrophy and narrowing of the terminal pulmonary arteries occurs to protect the overdistended, thin-walled left atrium from the force of the contraction of the right ventricle, so that even after the mitral stenosis is corrected and pressure in the left atrium is reduced, it takes some weeks or months for the obstruction to the flow of blood in the lesser circulation to regress.

It has been reported that, in aortic valvular disease, sudden death may occur during anesthesia. This is supposedly due to the associated narrowing of the adjacent openings of the coronary arteries. The anesthesiologist should watch such patients closely for signs of cardiac distress and should be prepared to lessen the stress of anesthesia and operation whenever such is indicated to protect the patient.

### Evaluation

Once a correct and accurate diagnosis of the pathologic changes in the patient's heart and circulatory system has been made, the effect of such changes on the functional ability of the heart must be evaluated. Almost any defect decreases the cardiac reserve to some extent, and it is important to know just what the extent is.

The most reliable criteria of cardiac reserve are based on the history of the patient's exercise tolerance. If the patient is able to perform his usual activities without disability and if he experiences dyspnea or angina only after unusual physical exertion, he probably has only a moderately decreased cardiac reserve and would represent a fair risk for a short operation which did not require a deep level of general anesthesia. At the other extreme, the patient who is dyspneic at rest and has orthopnea and pulmonary edema, enlarged liver, and ascites or edema of the dependent parts of the body has almost no cardiac reserve and represents an extremely poor risk for any type of anesthesia or operation. At present, estimation of cardiac reserve is based on the experience and judgment of the examiner and the answers of the patient to such simple questions as: How far can you walk at a moderate pace without becoming short of breath? How does this compare with your ability one year ago?

The cardiac output in man may now be determined according to the Fick principle by cardiac catheterization or by the dye-dilution method, and the response of the cardiac output to graded physical exercise offers a basis for the development of a method of objective determination of cardiac reserve. However, such procedures cannot be used to replace clinical judgment.

The opinion of an experienced cardiologist is a great help to the anesthesiologist in estimating the cardiac reserve. However, the duty of the cardiologist should consist of making the diagnosis and evaluating the physiologic status of the individual patient but should not consist of making recommendations about the use of specific anesthetic agents or technics with which he is less familiar than is the anesthesiologist. The planning of the anesthesia and the responsibility for its successful conduction should be left to the anesthesiologist after he has been armed with the counsel and interpretations of his cardiologist colleague. If the internist does give detailed orders about the anesthetic agents or methods, he only hampers the freedom of action of the anesthesiologist and thereby reduces the chances that the patient will be carried safely through a dangerous period.

### Planning

After the pathologic changes in the heart have been diagnosed and the physiologic ability of the heart has been estimated, the anesthesiologist is ready to plan the anesthesia so that the patient will have the best chance of survival and so that the surgeon will have the best operating conditions allowable. The requirements of the proposed operation must be understood, and the surgeon and anesthesiologist should discuss their mutual problems. In what position will the patient be? How deep an anesthesia will be necessary, and how much relaxation will be required during each phase of the operation? What will be the approximate duration of the operation? What are the chances that loss of blood may be rapid or excessive?

The nature of the specific anesthetic agent or method employed seems to be much less important than the philosophy of the anesthesiologist. Most of the available agents and methods are being used successfully by one anesthesiologist or another, and various combinations have their advocates.

My philosophy has been one of simplicity and conservatism. At the Mayo Clinic all patients with cardiac disease who are to have elective operations are prepared for operation by a cardiologist. Every advantageous therapeutic agent is employed, the cardiac reserve is increased to the maximum, and the time for operation is carefully selected to coincide with the time when the patient is best able to undergo the surgical risk. Almost nothing constructive or beneficial is left for the anesthesiologist to do. Conversely, almost everything associated with the anesthesia and the operation in the operating room is of necessity detrimental to circulatory efficiency. In such a situation it has seemed logical to me to do just as little as possible. Just as few drugs in just as small doses as possible are used. Before I use a drug I must be convinced that it is definitely indicated and that the advantages to be gained from its use are greater than the disadvantages that accompany the use

of almost every drug. The maintenance of an adequate flow of fully oxygenated blood to the tissues, especially those of the heart and brain, is the basic objective toward which all efforts are directed.

*Preanesthetic Medication.* The preanesthetic medication and the anesthetic medication are parts of the same process. They should be co-ordinated and should supplement each other. In general, a weak anesthetic agent will be combined with heavy premedication and vice versa. Since I frequently use ethyl ether, a potent anesthetic agent, during major operations, I am inclined to employ light premedication.

The barbiturates in large doses have been shown to have a deleterious effect on the cardiac output of animals, but human beings with cardiac disease tend to tolerate small doses well. The hypnotic effect of 50 to 100 mg. of pentobarbital by mouth seems to be beneficial for most adults who are not sensitive to the drug. During the anesthesiologist's preanesthetic visit, it is necessary for him to ascertain the patient's past reaction to all drugs which may be used during the operation.

In the past, morphine and other opiates have been used extensively in the treatment of acute cardiac emergencies and have served well. According to our present understanding, the opiates decrease the demand of the tissues for oxygen; and the psychic sedation produced is desirable. For this reason, moderate doses of morphine have been given to most patients. Slightly and proportionately larger doses are given to patients with cyanotic heart disease before they are anesthetized. Lowering of body temperature by physical methods has not been used as a preanesthetic measure, but it seems a logical method for decreasing the oxygen demand. A water mattress on the operating table has been employed to prevent a rise in body temperature during operation on many children, and the body temperature has been lowered a few degrees below normal in some of the children with cyanotic heart disease.

There is wide variance of opinion among anesthesiologists concerning the belladonna drugs as preanesthetic agents. Perhaps a lot depends on one's past experiences. Personally, tachycardia has been the most deleterious cardiac arrhythmia encountered, so I have used small doses of atropine or none at all before anesthesia in an attempt to prevent or reduce the incidence and severity of tachycardia. Even though no atropine is given to many patients (routinely none before mitral commissurotomy), I have failed to see any instance of bradycardia due to excessive vagal action and have not given any atropine intravenously during anesthesia. In spite of elimination of the preanesthetic administration of atropine, no excessive secretions have resulted, even during ether anesthesia.

*Local Anesthesia.* Since all anesthesia is detrimental to some variable extent for the patient with cardiac disease, a good general rule is that the least anesthesia is the best. For all operations for which it is adaptable, local anesthesia is probably best for the cardiac patient since only part of the body is anesthetized and the anesthetic agent causes only slight systemic effects so that an adequate number of reflexes to stress remain active. There are, however, definite limitations to the advantageous use of local anesthesia. If it is doubtful whether all pain can reasonably be prevented with local anesthesia, it may be better to plan an orderly general anesthesia during surgical procedure than to have to supplement local anesthesia with general anesthesia administered under disadvantageous circumstances. Local anesthesia can be intentionally combined with general anesthesia from the beginning with advantage in many operations. Local anesthesia is most useful for operations of short duration on the extremities, head, neck, and thorax. Used alone, it is generally not advantageous for intra-abdominal operations.

*Spinal Anesthesia.* Spinal anesthesia is less safe than local anesthesia for the patient with cardiac disease because it results in greater physiologic alterations. Decrease in overall peripheral circulatory resistance and decrease in venous return to the heart may result in a fall in blood pressure and decreased coronary blood flow. However, many facilities for the control of blood pressure are available today, and the use of spinal anesthesia has increased. In my experience, low spinal anesthesia for such operations as transurethral prostatic resection and vaginal hysterectomy has been well tolerated by patients with moderate cardiac disease. Spinal anesthesia has even been advocated for the treatment of cardiac decompensation. When this type anesthesia is combined with a head-up position, blood is pooled in the lower extremities so that venous return and

venous pressure are decreased and the necessity for phlebotomy may be avoided.

*General Anesthesia.* If general anesthesia is administered to the patient with cardiac disease, the level of anesthesia should be kept as light as is consistent with the production of good operating conditions. The vasodilation and other adverse effects of general anesthesia are directly proportional to the depth of the anesthesia produced. Curare preparations have made it unnecessary to anesthetize a patient beyond the first or upper second plane of the third or surgical stage of anesthesia. Provided adequate pulmonary ventilation is maintained, curare in clinical doses has few if any deleterious effects on the circulatory mechanism.

It seems to be possible for almost all of the general anesthetic agents to be successfully used for operations on patients with cardiac disease when administered according to the technics reported in the medical literature. On the other hand, I do not believe that there is any agent that cannot be misused when improperly administered. It has been my impression that the use of ethyl ether for at least part of the maintenance of general anesthesia in patients with cardiac disease has been advantageous because in light anesthesia respiration is not depressed and cardiac arrhythmia is less frequent. However, ether is not considered essential and is not used if its disadvantages are considered to be greater than its advantages in the individual patient. The decision as to the best general anesthetic agent awaits further investigation of the pharmacologic effects of all the agents in man.

The induction of general anesthesia should be quiet and without excitement, struggling, breath-holding, or cyanosis. Contrary to general opinion, the induction should not be rapid but instead should be deliberately slow and progressive. Time should be allowed for the observation of the reaction of the patient to increasing concentrations of the agent. Changes in blood pressure, pulse rate, and cardiac rhythm must be watched carefully and the anesthesia altered accordingly. By a slow induction, serious complications can be prevented or at least treated while still minor.

During the maintenance of anesthesia, the object of the anesthesiologist should be to give as little of the agent as possible and to keep the level of anesthesia as light as the stage of the operation at any moment will allow. Such close coordination of the anesthesia with the operation requires that the anesthesiologist possess a thorough knowledge of the surgical procedure and the surgeon in order that he may anticipate the operating conditions which will be needed well in advance of the time when the surgical maneuver will be executed. The condition of the patient must be watched closely for any deviation that might progress to a serious complication if unnoticed or unheeded. Each change, especially in the circulatory system, should be carefully evaluated. A direct-writing electrocardiograph is a valuable aid in continuously monitoring the function of the heart and in objectively emphasizing changes which could easily be overlooked if palpation and auscultation were the only methods available. An electrocardiograph is an absolute necessity for the accurate diagnosis of some cardiac changes which occasionally occur during anesthesia, such as in diagnosing the origin and significance of some of the arrhythmias.

*Supportive Therapy.* Delicate decisions frequently have to be made concerning supportive therapy of cardiac patients during anesthesia and operation. Dehydration is to be avoided, but administration of fluid of the wrong kind or in excessive amounts may be serious. Blood volume should be kept constant in order to maintain blood pressure, but an increase in blood volume may precipitate cardiac decompensation in the patient with a low cardiac reserve. The weighing of used sponges and the collection of aspirated blood in calibrated containers are most helpful in making an objective estimation of the blood loss during operation. It has been my objective to keep blood replacement 100 to 300 cc. less than the estimated blood loss.

Many valuable and potent drugs are available for administration during anesthesia. All have their place when specifically indicated, but too often one after another is rapidly administered in a real or imagined emergency without due consideration or diagnosis of the situation and without any good indication for the use of many of them. Several effective vasopressors which have little effect on the heart itself are on the market. I have found these vasopressors to be rarely necessary for maintaining the carefully guarded blood pressure of the patient with cardiac disease.

Several preparations of digitalis may be administered intravenously and expected to have a rapid effect. The indications for digitalization are not clear-cut, and I have hesitated to give digitalis during anesthesia without the advice of the cardiologist who prepared the patient for operation. This is especially true if the cardiologist has not considered digitalization necessary for the preoperative preparation of the patient or if the cardiologist has already given to the patient what he considers an adequate dose of digitalis. Progressively increasing and severe tachycardia without evident cause and pulmonary edema or other signs of eminent cardiac decompensation have been the more frequent indications for digitalization during anesthesia.

Strangely enough, the only three instances of acute pulmonary edema during anesthesia which I have observed occurred in patients who preoperatively had been considered to have no or only slight cardiac disease. Levine[1] has stated that congestive heart failure rarely develops as a result of surgical operations and that postoperative complications and fatalities among cardiac patients are much the same as those among noncardiac patients.

### Summary

Safety in anesthesia for the patient with cardiac disease is attained by accurate diagnosis of the pathologic changes in the heart, skilled evaluation of cardiac reserve, planning of the anesthesia and operation to avoid excessive stress, and early diagnosis and treatment of complications. Selection of a specific anesthetic agent or method is of relatively little importance.

Mayo Clinic.

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## SUMMER CAMP FOR DIABETIC CHILDREN AT LAKE GENEVA

For the sixth season, a summer camp for diabetic children will be opened at Holiday Home, Lake Geneva, Wisconsin, from July 18, 1954, to August 8, 1954, under the auspices of The Chicago Diabetes Association, Inc.

In addition to the regular personnel of the camp, there will be a staff of resident physicians and dieticians trained in the care of diabetic children. This staff is furnished by The Chicago Diabetes Association.

Boys and girls from eight through fourteen years of age are eligible. For further information regarding fees, write or phone the office of The Chicago Diabetes Association. Fees will be set on a sliding scale to meet individual circumstances.

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to:

The Chicago Diabetes Association
5 South Wabash Avenue
Chicago 3, Illinois
Andover 3–1861

Limited capacity requires prompt application.

# TACE*—A Long-Acting Estrogen Administered Orally Using the Vaginal Glycogen Index as a Basis for Human Assay

By DONALD C. AUSMAN, M. D.
Milwaukee

THE vaginal smear is useful as a guide to estrogen therapy in the menopause. Such a method is of particular value in those patients in whom emotional and psychic factors make reliance on control of subjective symptoms hazardous.

The high glycogen content of the normal vagina during sexual maturity and its diminution or complete absence in the hypo-ovarian states, particularly the menopause, has been ably demonstrated by many investigations.[1]

A convenient, rapid method of determining estrogenic activity in human subjects was devised by Mack[2-5] and is based on the affinity of iodine and glycogen.

The importance of this simple method for investigating ovarian functions and its practical value in estimating therapeutic responses is readily apparent.

### Technic of the Iodine Vapor Method

*Preparation of Smears.* A moistened cotton applicator is inserted into the vagina and twirled lightly (one complete rotation) against the vaginal wall. The cotton end of the applicator is then rolled lengthwise over the surface of a clean glass slide. The film dries almost immediately and may be stained at once.

*Staining of Smears.* Staining is accomplished simply by laying the slide, face down, over a shallow dish containing a small amount of fresh Lugol's solution. Iodine vapors which arise insensibly from the solution suffice to stain the glycogen-containing cells in three minutes. Microscopic examination may be carried out immediately.

*Grading of Smears.* **Grade 1.** Smears of this type contain only small yellow cells of varying sizes and shapes and large amounts of amorphous cellular debris. There is usually only an occasional glycogen-containing cell.

**Grade 2.** This grade is marked by greater abundance of epithelial elements than Grade 1. The stained glycogen is found in irregular brown deposits at the cell margins or scattered through the cytoplasm. Many glycopenic yellow cells are present, and less than one-third of the cells contain glycogen.

**Grade 3.** A further increase in cell numbers is shown; the cells are larger and more regular. The diffusely stained cytoplasm has a light brown color, and from one-third to two-thirds of the cells contain glycogen. This grade represents good estrogenic effect.

**Grade 4.** This grade is easily recognized by the presence, almost exclusively, of large, flat, deeply stained brown iodophilic cells present singly or in large clumps. The grade represents maximal estrogenic effect.

By the use of this Vaginal Glycogen Index, vaginal smears containing a normal amount of epithelial glycogen; *i.e.*, smears from women with normal ovarian function or menopausal patients who have received adequate estrogenic therapy, are recognizable microscopically by the cell type and deep brown color imparted by the iodine stain (Grade 3 or 4).

Following the cessation of estrogenic therapy, the Mack test usually reverts promptly to the glycopenic state (Grade 1 or 2). In studies on six oral estrogens, Mack[2] reported the average duration of effect following the end of a course of therapy to be from 5.3 days in the case of sodium estrone sulfate (1.25 mg. daily) to 13 days for a mixture of estrone with estriol (1.0 mg. daily) (Fig. 1).

Thompson and Werner[6] reported a new estrogen, TACE, which has a prolonged effect in animals following oral administration. This long activity is thought to be related to the fact that TACE is stored in the body fat of experimental animals.[6] Similar prolongation of effect is to be expected in human subjects since Greenblatt[7] reported the presence of regular and substantial

*TACE is the trademark of The Wm. S. Merrell Company, Cincinnati, for its brand of chlorotrianisene (tri-p-anisylchloroethylene).

amounts of TACE in human fat after its oral administration.

In the present study, the Mack test was utilized to determine whether the gradual release of TACE from the body fat would produce adequate estrogenic stimulation so as to prolong the period of estrogenic effect beyond the one or two weeks previously reported by Mack for the familiar estrogens.

TACE was administered orally to 16 women diagnosed as menopausal or having menopausal vaginitis and whose Vaginal Glycogen Index was Grade 1 or 2. Ages ranged from 36 to 65 years. Six of the patients took 24 mg. (2 capsules) a day, and the remaining ten received 36 mg. (3 capsules) daily. In the case of the 24 mg. dosage, all patients had a demonstrable increase in the duration of the effect of TACE, as measured by the Mack test, increasing to Grade 3 or 4. In two cases the smears were still typical of estrogenic stimulation one month after stopping treatment; in two others, after two months; and in the other two cases, the smears were still Grade 3 after three months. The average duration of estrogenic stimulation was, therefore, two months in this group (Fig. 2). The series of ten patients who received three capsules daily included three patients without evidence of prolonged action, two patients whose smears were Grade 3 or 4 after one

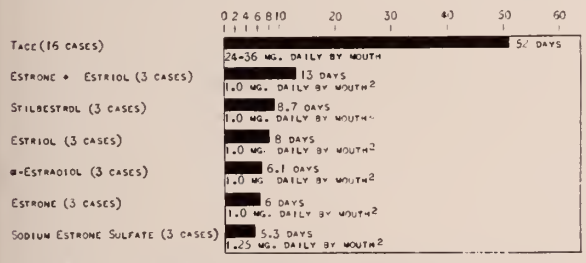


**Fig. 1—Average duration of estrogenic effect after stopping medication.**

month (Fig. 3), and three in whom they were still Grade 3 after two months. In the remaining two patients, smears still stained in the manner characteristic of estrogenic stimulation four months after the last dose of TACE.

The symptomatic response to TACE followed the estrogenic levels as reflected in the vaginal smear. The patients were relieved of their usual symptoms and experienced a sense of well-being during the periods when iodine staining produced the characteristic

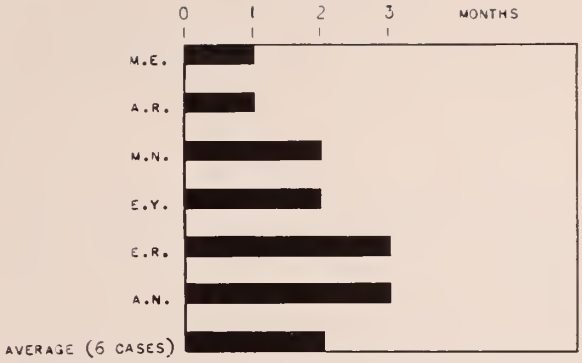


**Fig. 2—Individual duration of estrogenic effect following withdrawal of TACE (24 mg. daily by mouth).**

brownish hue in the smears. In most of these patients, there was no return of symptoms even after the smears showed little or no evidence of estrogenic stimulation. This is very different from the clinical results following the discontinuance of other estrogens, none of which are stored in the body fat.

## Comment

The unique property of TACE which permits it to be stored in the body fat from which it is released gradually during and following oral administration is responsible for certain clinical advantages. The highly gratifying symptomatic response characteristic of TACE therapy in the menopause results from the smooth action of the estrogen, which is gradually but constantly supplied from the body fat. Of equal potential importance is the probability that when the drug is discontinued after a single course of

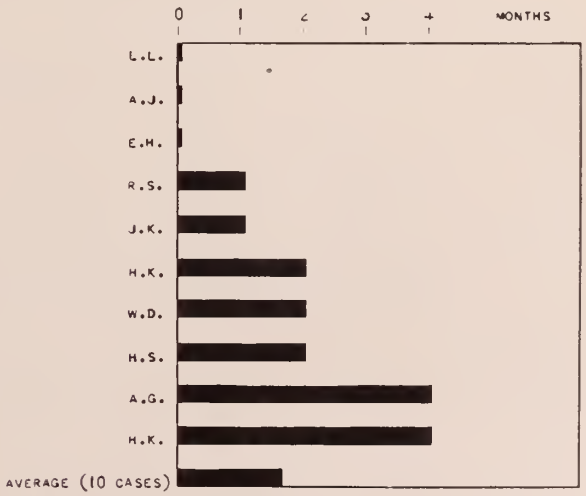


**Fig. 3—Individual duration of estrogenic effect following withdrawal of TACE (36 mg. daily by mouth).**

therapy, gradually decreasing estrogenic effects over a prolonged period of time will help many patients to adapt themselves to the normal postmature state in which estrogens are not needed.


### Summary

Sixteen menopausal women have been treated with a new estrogen, TACE. Prolongation of action of from one to four months was demonstrated by means of the Mack test in thirteen of the sixteen patients. Symptomatic improvement was closely related to the improvement in the vaginal smears. In those cases obtaining prolonged effects from TACE following termination of one course of therapy, normal adaptation occurs frequently so that further courses are not necessarily required.


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(The author is indebted to Kathryn Zetzman, Helen Ellis, and Catherine Spain, who cooperated in this research problem).

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## OTOLARYNGOLOGY COURSE OFFERED BY UNIVERSITY OF ILLINOIS

The Department of Otolaryngology, University of Illinois College of Medicine, announces its basic science course in otolaryngology offered by its affiliated hospitals. This combined postgraduate course and residency will begin its 1954–55 session on July 1, 1954. Other openings occur throughout the year. Residencies are available at either the Research and Educational Hospital or the Illinois Eye and Ear Infirmary, or a continuation of the training program may be arranged for the Veterans Administration Hospital at Hines.

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# Epidemic Hemorrhagic Fever*

By ELBERT DeCOURSEY, BRIGADIER GENERAL, MC, USA
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EPIDEMIC hemorrhagic fever is a disease peculiar to northeastern Asia. The earliest descriptions appeared under a variety of designations after 1934 in the Japanese and Russian literature. The disease was practically unknown to western medicine before 1951, when outbreaks first occurred in United Nations troops in Korea; but by the summer of 1953 there had been approximately 2,000 cases among U. S. forces, with about 120 deaths. The first American publication was by Colonels Steer and Hullinghorst[1] in the spring of 1952, subsequent to a request of the Armed Forces Institute of Pathology and Dr. H. T. Karsner. The disease, often referred to as EHF, is characterized by a sudden onset, fever, malaise, anorexia, vomiting, hemorrhagic manifestations, hypotension, and renal abnormalities.

The etiology is not established, although in 1940 Smorodintsev and other Russian investigators described the reproduction of a similar disease in man[2] by intravenous or intramuscular inoculation of serum or urine from patients in the early stages of the disease (less than 5 days). Such serum, after passage through a Berkefeld filter, similarly produced the disease following an incubation period of 12 to 16 days. Success in growing a causative agent in cultures or in establishing the disease in animals has not been achieved despite intensive study by the ablest of American workers. Entomologic data implicate a nonirritating trombiculid mite (chigger) as the probable vector. A rodent, probably the field mouse, is believed to be the reservoir. Distribution has been distinctly seasonal, with peak incidence at the beginning of summer and in the late fall. Variations in race, sex, or age seem to be slight.

The incubation period is known to vary from 9 days to 5 or 6 weeks. Therefore, the diagnosis of epidemic hemorrhagic fever should be considered in any patient who has recently returned from the Asiatic endemic area with mild to severe symptoms suggesting influenza, meningococcic septicemia, infectious mononucleosis, scarlet fever, typhus, purpura, or acute renal failure. The epidemics involving Americans have been localized and small, seldom involving more than 12 to 14 patients, occurring in a "flurry" lasting about a week. Most of the cases have been sporadic. Transmission from person to person has not been seen. In 1951 over half of the fatalities occurred during the first 8 days and almost 90 per cent by the fourteenth day.[3] At least 4 deaths from the disease have occurred on this continent.[4]

Clinically, epidemic hemorrhagic fever follows a fairly typical course, with severity ranging from a mild influenzal type of infection to profound toxemia in which medical shock may dominate the early picture. Such shock has been noted in about 25 per cent of patients, and these comprise the "severe group." The course can be divided into several phases as follows: The *febrile phase*, lasting from 3 to 6 days, is characterized by sudden onset of influenza-like symptoms which may suggest a diagnosis of "fever of unknown origin"; an irregular fever of 101 F. to 106 F.; erythema of the face, neck, and adjacent portion of the chest; injection followed by edema of the conjunctivae (and the palate); later, petechiae, most commonly of the soft palate, conjunctivae, and axillary folds and, subsequently, elsewhere in the skin; development of severe thirst and excessive fluid retention.

The *hypotensive phase* lasts from a few hours to 3 days, appearing after the temperature falls. Alarming vasomotor instability with shock occurs in approximately 25 per cent of the patients. Petechiae become more numerous, but gross hemorrhages are not a feature. Much fluid may accumulate in the interstitial tissues, resulting in hypovolemia. This phase may be very mild, but circulatory collapse may intervene suddenly.

The *oliguric phase* appears in the second week of the disease, lasts from 1 to 6 days, and may overlap the hypotensive phase. The blood pressure rises, occasionally to hypertensive levels. Acute azotemia, with sudden return of fluid from the interstices, may bring on distention of the veins and subsequent edema of the lungs. Uremia may de-

* Presented at the One Hundred and Twelfth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 7, 1953.

velop. The severity of the oliguria does not appear to be related directly to hypotension.[5]

The *diuretic phase* begins in the second week, with profuse diuresis and rapid improvement in the patient's general condition. Depending on the fluid balance, dehydration and secondary shock, or the other extreme of relative hypervolemia with pulmonary edema and secondary infection are untoward complications.

The *convalescent phase* may continue through the fifth or sixth week after onset. With rare exception, the clinical picture and urinary and blood tests return to normal during this time.

### Pathologic Anatomy

In general, the most prominent gross changes found at autopsy are early edema (Kessler)[6] and, somewhat later, petechiae or purpuric hemorrhages in various areas. Edema is seen early in the conjunctivae and the areolar connective tissue generally and is manifested by increased weight of nearly all parenchymatous organs, and wet serosal surfaces. It is particularly striking in the retroperitoneal tissue, which is distended with straw-colored fluid and appears gelatinous. Appreciable amounts of free fluid accumulate in the body cavities. This edema, occurring as late as the ninth day, subsides after the shock phase; and later, tissue dehydration is the rule.

Congestion, petechiae, and parenchymatous ecchymoses, for the most part, involve kidney, pituitary, heart, adrenal glands, gastrointestinal tract, conjunctivae, palate, skin, and brain but may be found anywhere. Pale areas of necrosis may appear in kidneys, pituitary and adrenal glands.

The kidneys, usually enlarged, exhibit progressive medullary congestion, then diffuse medullary hemorrhage, sometimes with streaks or areas of pale necrosis. The cortex is pale. This picture is so characteristic that it has been termed "EHF kidney."[3] Diffuse subepithelial hemorrhage often appears in the pelves and less frequently in the ureters, where it narrows the lumen. Microscopically, the glomerular spaces and the dilated convoluted tubules contain eosinophilic, albuminous fluid. In the pyramids, seas of red blood cells surround islands of degenerated or necrotic tubules which may suggest lower nephron nephrosis. Necrosis begins late in the first week and increases in amount with each phase, but the necrotic areas are not surrounded by a zone of infiltrating leukocytes. Thrombi and typical vascular occlusions are not found. Occasional small infiltrations of mononuclear cells appear around vessels in the pelvis.

The heart presents a characteristic diffuse hemorrhage in the right atrium, more prominent when viewed from the endocardial aspect. Elsewhere, occasional subendocardial hemorrhages and scattered petechiae may be seen. Microscopically, edema and hemorrhage appear in the atrial musculature. Edema and small areas of mononuclear infiltration are found in the endocardium in any chamber, and less often in the myocardium. These subendothelial infiltrations are progressively less common after the shock phase and are considered characteristic by Steer.[7]

The anterior lobe of the pituitary is congested and frequently contains hemorrhages; and, in almost every case, areas of necrosis can be seen after 10 days.[8] Hemorrhages appear in the stalk and hypothalamus. Focal hemorrhages often appear in the adrenal cortex, usually the fascicular layer; but large areas of necrosis are uncommon. Here again there is lack of leukocytic zone around the necrotic tissue, so-called bland necrosis. Occasionally, microscopic foci of necrosis or of mononuclear infiltration are found in the pancreas and in the midzonal area of the liver lobules. These foci are similar to those seen with anoxia.

The superficial esophagitis in some instances is probably secondary to vomiting. In the gastrointestinal tract, intense mucosal congestion and submucosal edema are frequent; gross hemorrhage, though rare, is sometimes fatal. The congestion is usually most prominent in the stomach.

The changes in the hematopoietic system are apparently secondary. The bone marrow is often overactive or hyperplastic. The spleen is diffusely congested. Its follicles are small and microscopically do not have reactive centers. Mononuclear cells, plasmacytes, and granulocytes are numerous in the sinusoids.

The lymph nodes are somewhat enlarged and edematous. Some appear pinkish to red before petechiae are noted. The sinusoids are dilated and contain large round cells similar to those in the spleen. To previous authors they have not seemed worthy of comment, but red blood cells appear regularly in the

peripheral sinusoids of the nodes and the afferent lymphatics, at least by the fourth day. This would seem to be added evidence of early increased capillary permeability that gradually allows more and more erythrocytes to escape into the tissues and then to enter the lymphatics. Erythrophagocytosis is often present but not prominent until the fifth or sixth day.

The capillaries everywhere may be dilated and engorged, but this picture is particularly prominent in flushed areas of the skin and other grossly congested tissues. Actual breaks in the walls are not readily demonstrated. Perivascular infiltration may be seen in renal pelves, skin, and testes. Except for occasional swelling, changes in endothelial cells have not been demonstrated.

### Clinical Pathology

The blood and urine present abnormalities that vary in time of onset, duration, and degree. The changes are characteristically absent for the first 2 or 3 days, when only occasionally leukopenia and immature granulocytes are seen. Serologic, bacteriologic, and related microbiologic procedure results have been uniformly negative after extensive research.

*Urine.* Most important is the sudden appearance of a three or four-plus proteinuria, usually about the fourth day. Without proteinuria, the diagnosis cannot be confirmed (until a specific test is discovered). Oliguria soon begins and reaches its maximum between the sixth and eighth days, soon followed by diuresis, with a daily output of 2 to 4 liters; proteinuria now disappears. Meanwhile, the early high specific gravity falls to 1.010 or below as the oliguria increases. The return to 1.020 and above affords one of the most important changes that can indicate convalescence to a point where the patient may resume ambulation. Red blood cells, granular cells, and casts are proportionally more numerous in the urine than epithelial and white blood cells. All these urinary findings are most conspicuous from about the sixth to the tenth days.

*Blood.* Leukocytosis of 10,000 to 20,000 white blood cells per cubic millimeter is usual and occasionally reaches leukemoid proportions. This appears about the end of the first week, with a second but lower peak at the end of the second week. An early pronounced shift to the left disappears by the third week, and the count returns to normal in convalescence. Mature and immature cells of all types may be seen in the peripheral blood in the second week. The hematocrit reading, as well as the erythrocyte count and the hemoglobin content, is elevated exceedingly with the onset of hypotension.

Thrombocytopenia and prolonged bleeding time, with normal prothrombin and coagulation times, are found in most of the patients at about the end of the febrile phase.

The blood urea nitrogen, nonprotein nitrogen, and creatinine are elevated to maximum levels during oliguria, their elevations varying directly with the duration and degree of oliguria. Serum potassium and inorganic phosphorus may be increased. Elevated cephalin-cholesterol flocculation and thymol turbidity are common.

### Relation of Symptoms to Lesions

In our present state of ignorance, we can hardly speak of fundamental lesions. The edema and hemorrhagic phenomena are the most conspicuous and obviously incriminate the vascular walls. It would seem that the most likely primary lesion is in the walls of small blood vessels or in the mechanism that controls capillary permeability. The theory has been advanced that the basic pathologic process is vascular paralysis or capillary fragility.[9] Capillary dilatation, stasis, and extravascular red cells give the picture of gross hemorrhage in several locations, such as the kidney, heart, pituitary, and gastrointestinal tract. Increased capillary permeability is evidenced by the early edema and proteinuria. Later diapedesis of red blood cells results in hematuria and petechiae. Even the development of the hemorrhagic phenomena supports the idea that the increased vascular permeability goes hand in hand with ever-enlarging spaces in the vessel walls. At first there is leakage of small molecules of transudate, then larger molecules of protein, and finally red cells. The lymphadenopathy which begins on the second day probably results from the increased amount of fluid flowing into the sinusoids. As fluid leaves the vascular tree, the blood becomes concentrated; and hypovolemia follows. First, the erythrocytes escape in small numbers and pass through the tissues into lymphatics and lymph node sinuses. Then, in progressively larger numbers, they form petechiae and, finally, parenchymatous

hemorrhages. What part do the thrombocytes play in this vascular dilatation and leakage? If platelets release the vessel-constricting serotinin and if they plug the sieve-like leaks of the walls, a decrease or disease of platelets would explain the congestion, edema, hemorrhages, and even the hypotension from vascular dilatation. The lack of a susceptible laboratory animal prevents the testing of this working hypothesis as Furth and Cronkite have demonstrated in the mechanism of radiation injury. The stasis and hemorrhages may account for local anoxia, followed by coagulative necrosis in the kidneys and pituitary. In such areas, stasis probably also prevents the mobilization of leukocytes which might be expected to form a distinct zone between healthy and dead tissue. Necrosis was less in the 1952 cases in which fluids were withheld and normal blood pressure maintained by noradrenalin. In the kidneys and urinary tract, the hemorrhages and their sequelae explain not only most of the urinary changes, but also some of the back pain. Retroperitoneal and perirenal edema also contribute to this pain. Headache, restlessness, and irritability from edema and hemorrhage of the brain; retrolobular pain from periorbital edema; and congestion and hemorrhages all are consonant with the concept that most of the signs and symptoms originate from vascular leakage.

### Treatment

The current therapy consists of a regimen of absolute bed rest, adequate sedation, pressor drugs, salt-poor albumin, Trendelenburg position and strapping of the extremities to combat shock, and careful control of fluid balance until oliguria and vasomotor instability have been overcome.

### Summary

1. Epidemic hemorrhagic fever is an acute febrile disease that is endemic in northeastern Asia.

2. The cause of epidemic hemorrhagic fever is uncertain. Some evidence implicates a filterable virus as the etiologic agent, a trombiculid mite as the vector, and a rodent as the reservoir.

3. The pathology of the disease provides the only basis for the entire interpretation of the clinical manifestations. The basic pathologic change is increased vascular permeability with edema, serous transudate, and hemorrhages. The kidneys, pituitary, adrenals, heart, and gastrointestinal tract are principally affected. Medullary hemorrhages and necroses give a characteristic renal picture, "the EHF kidney." Mononuclear infiltrations appear in the heart, spleen, and lymph nodes.

4. Epidemic hemorrhagic fever is characterized by the sudden onset of a mild to severe influenza-like syndrome that progresses through febrile, hypotensive, oliguric, diuretic, and convalescent phases. The diagnosis is entertained in a febrile patient who has recently been in Korea and who shows hematopoietic, renal, and cardiovascular involvement. Combined urinary and hematologic laboratory findings are strongly suggestive, and proteinuria is necessary for confirmation of the identity of the disease.

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# Use and Distribution of Gamma Globulin*

By W. D. STOVALL, M. D.**
Madison

IT IS not surprising that gamma globulin was chosen as a prophylactic immunizing agent in an attempt to prevent poliomyelitis or to control its terminal effect. That convalescent serum contains immunizing substances against certain communicable diseases has long been a matter of common knowledge. The first use of this knowledge came through the control and prevention of measles. In the late twenties the protective effect of this fluid against measles and some other communicable diseases suggested the possibility that convalescent serum would be useful in the treatment of patients acutely ill with diagnosed poliomyelitis. This proved to be a forlorn hope after it had been tried in several well-controlled experiments.

For several years the protective substances in human adult plasma have been prepared by a series of precipitations with differing dilutions of alcohol under varying degrees of acidity and temperature and sold under the name of "immune serum globulin." In the meantime a means of testing the neutralizing effects of this substance for poliomyelitis virus has been devised. Mice susceptible to the Lansing type of the virus were used for this test. Now tissue culture is used for this purpose. It is less costly, and the tests are more conveniently carried out.

With this knowledge, Hammon and his associates, financed by the National Foundation for the Study and Prevention of Poliomyelitis, planned the first experiments to test the effectiveness of gamma globulin in the prevention and control of poliomyelitis in the human family. Provo, Utah, was selected for the first tests because of the prevalence of the disease there (160 cases per 100,000 people in all age groups) in the summer of 1951.

Mass immunization of all children in the age group of 1 to 11 years was carried out in the county. The results were not decisive but encouraging. In the summer of 1952 two cities, Houston, Texas, and Sioux City, Iowa, where the incidence reached 82 and 427 cases of poliomyelitis per 100,000 population, offered an opportunity to obtain more evidence of the prevention and control value of gamma globulin.

In each instance, mass immunization was undertaken for children in the age group of 1 to 11 years. Criteria and controls were established so that inconclusive results would be prevented in so far as possible. The important requirements were (1) that statistically significant numbers of children be enrolled in the experiment; (2) that random injection of volunteers be the plan for inoculation, one-half receiving an injection of a solution of gelatin, the other half getting gamma globulin; and (3) that paralytic cases be used for the analytical statistical studies. In the experiment 55,000 children were given an injection, half of them receiving gamma globulin, the others a solution of gelatin. In the group of injected children, one hundred four contracted poliomyelitis of the paralytic type; 31 cases occurred among those who received gamma globulin and 73 among those in the control group. During the first week following the injections, the incidence of paralyzed cases showed no significant difference in the two groups; there were 12 cases in the gamma globulin group and 16 in the gelatin group. However, in the second week there was a significant difference; there were 3 cases in the gamma globulin group and 24 in the gelatin group. This difference in the incidence of paralyzed cases continued through the fifth week. There was some evidence, however, that some protection lasted through the eighth week. Of great import was the suggestion that in those cases in which the disease occurred in the first week, there was evidence that severity was modified. The ratio of protection was approximately two cases prevented or modified per 1,000 persons receiving the injection.

This information became known to those most concerned with the recruitment of whole blood and the preparation of blood products for the departments of national defense, military and civilian, and for the civilian population early in 1952. It alerted

* The plan for the distribution of gamma globulin during the polio season of 1954 will be found in The Wisconsin Medical Journal for April 1954, page 269.

** Director, State Laboratory of Hygiene.

them to the perplexing problems of securing and equitably distributing gamma globulin for the poliomyelitis season of 1953. The problems were indeed perplexing because gamma globulin was in short supply. Not more than 1½ million doses were available from all sources for 43 million children in the age group at the most hazard, the group from 1 to 15 years of age.

| AGE | Amount of Globulin to be Issued and Administered |
|---|---|
| Under 6 months | 2.0 cc. |
| 6 months through 2 years | 3.0 cc. |
| 3 years through 20 years | 1.0 cc. per year |
| 21 years through 30 years | 20.0 cc. |
| Pregnant women—any age | 20.0 cc. |

Because the immunity conferred by gamma globulin is of short duration, the deficiency in the supply was further exaggerated. There were other disadvantages, too, in attempting to distribute an insufficient supply of gamma globulin for all people whose hazard would be the greatest. There were no methods for determining the susceptibles from the non-susceptibles which made mass immunization a waste of scarce material. All of these deficiencies were magnified in view of the fact that many atypical and unsymptomatic individuals carry the viruses of poliomyelitis and are spreaders of the disease. This hidden reservoir of virus spreaders made it impossible to be aware of the time or degree of intimacy of exposure to infection. In this situation mass immunization was the apparent method of choice; but the amount of gamma globulin was insufficient, except for selected epidemic areas, and advance selection of such areas was not possible.

Although knowledge of the disease and technical practices that are feasible for nation or community-wide application were lacking, there were some facts which were helpful in devising a plan for the distribution of the limited amount of gamma globulin in a fair and just manner.

In periods of high incidence of poliomyelitis, individuals living in the house with the index case are at five to twenty times greater risk than the public at large. It was estimated that within the week following the occurrence of a diagnosed case of poliomyelitis in a family, 75 per cent of the children and 50 per cent of the adults are carrying and shedding the virus. On the basis of risk, the priority of household contacts of index cases seemed equitable.

This was further supported by Hammon's report, which suggested that during the first five days of household contact, gamma globulin may have a modifying effect on the disease, although it does not prevent it, and in the next seven days, the period during which 30 per cent of the secondary household cases came down with the disease, it has preventive value. While 60 per cent of the secondary cases in the household will come down too soon to obtain prophylactic results, there are 30 per cent which are delayed long enough to get some modifying benefits and 10 per cent among whom prevention may be accomplished.

There are additional factors which favor distribution of gamma globulin on the basis of household contact. Some of these are (1) distribution can be made according to the occurrence of cases; (2) it can be carried out through established administrative channels; and (3) it requires a relatively small amount of the gamma globulin available and thus leaves some for mass distribution in epidemic areas and for special studies.

*Estimated Number of Secondary Cases in Households Per 1,000 Cases of Paralytic Poliomyelitis—Interval Between Cases and Degree of Prophylaxis*

| Days Interval Between Index and Secondary Cases | Number of Secondary Cases Per Thousand Paralytic Cases | Per Cent Secondary Cases | Degree of Possible Prophylaxis |
|---|---|---|---|
| 0 to 5 days | 30 | 60 | None |
| 6 to 12 days | 15 | 30 | Modification |
| 13 to 30 days | 5 | 10 | Prevention |
| Total | 50 | 100 | |

## National Plans***

With this evidence for the value of gamma globulin in the prophylaxis of poliomyelitis, the Office of National Defense requested the National Research Council for assistance in the development of plans for equitable and effective means for its distribution. The council, with the advice of representatives from various experienced and interested groups, decided that a plan of controlled distribution was essential; that within the states, gamma globulin would be distributed through the state health department; that each state would receive a basic supply for poliomyelitis based on the experi-

*** Since this paper was written, the report of the use of gamma globulin during the polio season of 1953 has appeared in the Journal of the American Medical Association, volume 154, No. 13, March 27, 1954, page 1086, under the title "Evaluation of Gamma Globulin in Prophylaxis of Paralytic Poliomyelitis; Report of Committee for Evaluation of Gamma Globulin."

ence of the state over the past five years, 1947 to 1952; that additional amounts would be furnished on the basis of current experience; that the plans for distribution within the state would be worked out by the individual state health department; and that gamma globulin for mass immunization would be approved on the basis of the critical poliomyelitis incidence.

Feig made a statistical study of the incidence of poliomyelitis in Wisconsin over the five-year period, 1947 to 1952, and the age distribution of the cases; he commented on the significance of this incidence on the distribution and probable effectiveness of gamma globulin in Wisconsin in the summer of 1953. From the study made by Feig and from other considerations mentioned above, the State Board of Health, upon the advice of the consulting authorities, decided upon immunization of household contacts 19 years old and under and of pregnant women as the basic immunization program for Wisconsin and decided that mass immunization in any county would be undertaken only at the request of the county medical society, on the condition that the society assume the full responsibility for carrying out the program, and only when the incidence of the disease reached or exceeded the critical poliomyelitis incidence determined by the National Civilian Defense Agency.

National Civilian Defense, on the basis of supply available, allocated to the states 57 per cent of the available supply—after the requirements for measles and hepatitis were satisfied; withheld 33 per cent for mass community use; and kept 10 per cent for a national reserve to be used for unusual or special situations.

### Comments

1. From the information at hand, it was not expected in the beginning that gamma globulin would be the solution for the control and prevention of poliomyelitis.

2. Some of the limitations of gamma globulin as an immunizing agent for the prevention and control of poliomyelitis were understood at the beginning of the summer of 1953 and before. However, the experience at Provo, Houston, and Sioux City added to our knowledge of the role of gamma globulin in immunity to poliomyelitis in the human family.

3. The experimental evidence accumulated from the mass immunization programs has brought about a better understanding of some of the perplexing epidemiologic phenomena of poliomyelitis.

4. Advances in methods of tissue culture, the adaptation of poliomyelitis viruses to growth in tissue cultures, and the inhibition of their growth in these cultures by gamma globulin have enlarged the scope of epidemiological study and suggest a method for the development of an active, longer lasting immunizing agent.

5. The demonstration of anti-poliomyelitis gamma globulin in the plasma of blood collected from adults by the National Red Cross and other agencies throughout the United States is evidence of the widespread distribution of these viruses.

6. The mass immunization programs and the experience in Polk County in our state last summer have demonstrated that the cooperation of official and voluntary agencies can be effective in the organizing and carrying out with dispatch of a county mass immunization program.

7. Those persons living in a family where a case of poliomyelitis occurs are at much greater hazard than those in the community at large.

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# Use of Poliomyelitis Gamma Globulin—1954

## As It Looks to Your State Board of Health

THE plan for distributing gamma globulin for prophylaxis against poliomyelitis in 1954 was recently announced by the State Board of Health. This policy, drafted in cooperation with the State Medical Society, provides that gamma globulin will be available for group immunization of 10 or more children under 16 and for pregnant females. It will not be available for use in household contacts of poliomyelitis cases except as they are incidental members of a group program. Gamma globulin will also not be available for prophylaxis of poliomyelitis in counties where vaccine field trials are being conducted since its use would invalidate the field trials.

This revised policy is based on last year's experience in using gamma globulin both here in Wisconsin and in other states. General conclusions were that it was not of value in preventing cases of poliomyelitis or in reducing the incidence or severity of paralysis when given to protect family or household contacts.

The National Advisory Committee for Evaluation of Gamma Globulin* has reported that there was no significant difference in the extent of muscle involvement in those "household contacts" who received gamma globulin before onset, as compared with those who received none or received it on the day of or after onset. No significant difference was found in the proportion of patients classified as having nonparalytic disease. Subsequent cases that developed after the initial case followed a pattern similar to the one observed in previous years when gamma globulin was not used.

Such apparent lack of effectiveness is believed to have been due to the gamma globulin having been given to patients after they were infected. It may be of value if given before contact has occurred. It is believed probable that family contacts of a patient were already infected by the time diagnosis was made in the first case or by the time inoculations could be given. Another suggested explanation was that gamma globulin preparations may have contained too little antibody to be effective in the dosage used.

Based on the findings of this study, no gamma globulin is available for use in "family contacts." According to the directive from the U. S. Public Health Service charged with distribution, gamma globulin may be used only in group inoculations in groups larger than a single family, such as a neighborhood, a school, a camp, an area within a community, or a community as a whole. Larger doses are recommended (an increase of from 0.14 cc. to 0.2 cc. per pound of body weight).

Mass inoculation of gamma globulin was given in 23 communities in 13 states in 1953. Statistically measurable results were not obtained from this experience in mass use, however. Over half of the epidemics were considered too small or inoculations given too late (after the epidemic peak had been reached) to permit conclusions by the Evaluation Committee. A variety of approaches was used in the attempt at evaluation in the others. The lack of standardized materials and proper controls made it impossible to show any clean-cut results, according to the Committee. There were a variety of epidemic curve patterns, but they did not show any consistent difference when compared with curves from epidemic areas where no gamma globulin was given. Here in Wisconsin, as in other states, it is believed that the value of mass inoculations was decreased by delaying the immunizations until a high "critical incidence" existed in the area, a requirement found necessary because of the limited supply of gamma globulin.

The policy adopted by the State Board of Health and the State Medical Society for 1954 recommends that gamma globulin be used early, without waiting for a high community incidence. It was felt that this could be best accomplished by limiting its use to group immunization programs for 10 or more children under 16 rather than for

* The study was sponsored by the United States Department of Health, Education, and Welfare, United States Public Health Service, Communicable Disease Center, Atlanta, Georgia, in collaboration with the Association of State and Territorial Health Officers, the American Physical Therapy Association, and the D. T. Watson School of Physiatrics, affiliated with the University of Pittsburgh School of Medicine.

"family contacts." It has been demonstrated that gamma globulin offers its greatest protection beginning with the second week after immunization and lasting about four to six weeks. As the period of highest incidence of poliomyelitis in Wisconsin occurs during the months of August and September, it is recommended that physicians do not provide the immunizations until after July 1 unless the local incidence is higher than usual prior to that date. Details on how to obtain gamma globulin are given on page 269 of the April issue of *The Wisconsin Medical Journal.* Distribution will be handled by the district offices of the State Board of Health and the Bureau of Communicable Disease Control in Madison, beginning about June 1.—CARL N. NEUPERT, M.D., *State Health Officer.*

# ANNUAL MEETING HIGHLIGHTS

## Milwaukee, October 4–5–6

**GOLF TOURNAMENT: Monday, October 4, afternoon and evening.**

**HOUSE OF DELEGATES: Monday morning, October 4; Tuesday evening, October 5; and Wednesday morning, October 6.**

## *Special Scientific Programs and Headliners*

**MONDAY, OCTOBER 4:**

Afternoon General Session With:
*Leo Bartemeier,* M.D., Detroit: "What Patients Expect of Their Physicians"
*Paul Williams,* M.D., Dallas: "Low Back Pain"
*John Adriani,* M.D., New Orleans: "Surgical Risks from the Standpoint of Anesthesia"

**TUESDAY, OCTOBER 5:**

**Pediatrics:** *Robert Lawson,* M.D., Winston–Salem, N. C., and *Erling S. Platou,* M.D., Minneapolis

**Internal Medicine:** Hans Selye, M.D., Montreal, Canada, and *William Bean,* M.D., Iowa City

**Radiology:** *David Pugh,* M.D., Rochester, Minn., and case studies by Wisconsin MDs

**Orthopedics:** *Paul Williams,* M.D., Dallas, Texas, and *W. Brandon McComber,* M.D., Albany, N. Y.

(Afternoon General Program to feature Doctors Selye, Lawson, McComber, and Fred Fitz, Chicago)

**Anesthesia** (During afternoon. Official meeting of Wisconsin Society of Anesthesiologists): *John Adriani,* M.D., New Orleans, and *Albert Faulconer,* M.D., Rochester, Minn.

**WEDNESDAY, OCTOBER 6:**

**Obstetrics and Gynecology** (Official meeting of Wisconsin Society of OB & Gyn): *Howard Tatum,* M.D., New Orleans, and *John Brewer,* M.D., Chicago

**Cardiac and Pulmonary Diseases:** *Charles Cameron,* M.D., New York; second speaker not yet selected.

**Surgery:** *William Grove,* M.D., Chicago, and *Henry Doubilet,* M.D., New York City

(Afternoon General Program to feature Doctors Brewer, Cameron, and one other speaker not yet selected)

**Ophthalmology and Otolaryngology:** *Justin Donegan,* M.D., Chicago, *George Baker,* M.D., Rochester, Minn., and *Meyer Fox,* M.D., and *John Hitz,* M.D., Milwaukee. Program starts with lunch at 12:15 and continues through afternoon until 3:30 p.m.

**DINNER, DANCE, AND FLOOR SHOW:** Concluding feature of the Annual Meeting, Wednesday, October 6. Dance will follow banquet and floor show.

For Additional Highlights See Page 355 of This Issue

# Does Rural Wisconsin Need More Hospitals?*

By VINCENT F. OTIS**
Madison

THE people of Wisconsin, particularly those in predominantly rural areas, are witnessing the provision of greatly needed hospital and health care facilities unmatched in the history of the state. Stimulated in a large measure by the availability of federal grants-in-aid under the 1946 Hill–Burton Act, rural communities have constructed facilities which would otherwise have been impossible or replaced others which would have remained unsatisfactory because of lack of *adequate* local funds.

Hospitals constructed since 1946, structures now nearing completion, and projects fully approved during 1953 not only will provide 78 per cent of the total hospital beds urgently needed, but also will assure better health care to more than 1,350,000 persons living in 60 rural hospital service areas. It should be pointed out that Wisconsin is about 45 per cent rural today whereas the areas benefiting from recent hospital facilities are 75 per cent rural. How did all of this happen in just seven years? Through the presentation of this paper, maps, charts, and tables of information, an attempt will be made to summarize the progress of the past seven years and the outlook for the immediate future.

### A State Plan Was Developed

Through broad representation, thinking, and sound planning of the State Advisory Hospital Council and annual surveys by the State Board of Health, a state-wide plan was developed. Strategic locations were selected for hospital centers, which contributed towards a better utilization of hospital services and which encouraged a better distribution of physicians, surgeons, and other hospital personnel. During the past seven years, 1947 through 1953, 1,574 beds have been provided in 43 rural communities. During this period 41 old, obsolete hospitals have been replaced with 26 modern, fire-resistant structures, equipped to render a satisfactory hospital service. The net result has been fewer but somewhat larger hospitals, which, because of location and size, will serve more patients more adequately. Seventy-two per cent of the beds constructed in rural Wisconsin during this period were approved under the Hill–Burton program.

In view of the success achieved in providing such a substantial number of hospital beds for our rural population, just what is the remaining need? Does your own community *really* need a new hospital or an expansion of an existing one?

In recent years the shortage of hospital beds and the possibility of obtaining Federal grants to assist in the construction of needed facilities have intensified or created an interest in communities that never dreamed of having a hospital. While the question whether your community should build a new initial hospital needs to be answered, a more logical one in the great majority of communities in the state seems to be how many additional beds are needed for the existing hospital? In many instances, modernization of the present hospital plant, with a minimum bed expansion, is all that is needed.

The goal of reaching all of Wisconsin's rural population with satisfactory hospital care calls for a careful and constant review of the changes in our rural areas. This study is not needed to find out whether rural people are basically different from urban people in their needs and desires for medical and hospital care. It is needed because the social and economic conditions under which our rural people live are constantly changing.

1. *Increasing urbanization.* Wisconsin was 62 per cent rural in 1900 but is only 45 per cent rural today, a trend which certainly affects the location of the hospital as well as the bed need, since patients can come only from the particular area.

2. *Improvement of various types of transportation.* More and more miles of better roads, faster and more comfortable transportation, have brought people to hospital

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* Adapted from a presentation at Farm and Home Week, University of Wisconsin College of Agriculture, Wednesday, February 3, 1954, 2:15 p.m., Memorial Union Theater, Madison, Wisconsin (Sectional Program: The Rural Community; Better Health for Rural People).

** Director, Division of Hospital and Related Services, Wisconsin State Board of Health.

centers in greater numbers and in less travel time.

3. *Increased recognition of value of good medical care.* The emphasis on health education has had its effect on the use of medical and hospital care facilities. For instance, many of the twenty million or more veterans of World War II and the Korean conflict have experienced and will want modern medical and hospital care for themselves and their families.

4. *Improved living standards and growth of insurance plans.* In recent years higher incomes have enabled more persons to make greater use of available medical and hospital facilities; hospital and medical insurance plans are playing a greater part in making available these needed services when they become necessary.

### More Births Occur in Hospitals

Perhaps the single most significant barometer to illustrate these changing conditions is the number of births in Wisconsin's hospitals. In 1935, less than two decades ago, only one of every five rural babies was born in a hospital. In 1953, last year, 97 per cent were born in hospitals. In other words, almost all mothers from rural areas are using the hospital today. In the urban areas, with hospitals generally more accessible, the number of births in hospitals has increased from 58 per cent to 99 per cent during this same period. These statistics tend to refute the often-mentioned assumption that rural people are not as ready to use such facilities. Rural residents, as well as urban, appreciate the value of good hospital care and are demanding more facilities for their communities. However, we must resist this understandable desire to build more hospitals in more new locations, because there is danger that some rural communities may build hospitals which cannot be adequately supported or render the quality of service that rural people want and should have.

### Commission on Hospital Care Made Recommendations

The Commission on Hospital Care, a national, independent, nongovernmental agency composed of outstanding leaders from many fields, conducted an intensive two-year study of the nation's need for general hospitals from 1944 to 1946. The pattern of surveying and arriving at the needed hospital facilities developed by this Commission has been used as a guide by the states in the administration of the Hill–Burton Hospital Construction Act. The Commission made seven important recommendations which are repeated here because they apply specifically to hospital services for rural people:

1. Before any rural community builds a new hospital, a careful survey should be made of the local situation to determine the size of the area which the hospital is intended to serve, the number of people to be served, the amount and quality of *facilities available in nearby communities*, the cost of the proposed construction, the estimated cost of operation and maintenance, and the way in which the hospital would be integrated with nearby hospitals.

2. Hospitals should be constructed only where the size of the population and the availability of medical and technical personnel, transportation, and methods for financing the service justify the establishment and indicate *continuous successful operation of such facilities.*

3. The convenience of the patients and the accessibility of the institutions should be considered in the establishment of rural hospitals. The hospital community, the service or trading area, should be large enough so that adequate hospital service can be provided economically; but it must be small enough to be convenient for use by residents in the area.

4. The establishment of rural hospitals should be contingent upon a *reasonable* expectation that a high quality of medical care can be developed and maintained.

5. If a *real need* for a hospital in a low-income rural community can be demonstrated by application of accepted standards, the county, the state, and/or the nation should provide some sort of equalization fund or subsidy to assist the community in the construction and support of such a hospital. (The Hill–Burton program has provided subsidies for construction from the Federal level, and several states have added state grants-in-aid).

6. In order to provide for the health needs of the people in small communities in which it is impractical to establish hospitals of a minimum size, approximately 25- to 50-bed medical service centers (varying in type) should be established.

7. In order to maintain proper standards of service in small hospitals and medical

service centers and to provide for the continuing education of the physicians in these institutions, they should be affiliated with institutions in which comprehensive services and competent professional personnel in the special fields of medicine are available.

### A Plan Is Transformed into Action

How, then, has Wisconsin, through the State Board of Health, planned to meet these recommendations and, more important, what has it already accomplished? With the assistance of the State Advisory Hospital Council, the Board of Health developed a State Hospital Plan, which is revised annually. Seventy-five hospital service areas are established to contain no more than 125 hospitals, even though there are 165 in existence today. For example, in 60 predominantly rural areas there are now 110 general hospitals of all sizes, including a few maternity homes. We could get along with 70 rural hospitals, or 40 less, by expanding the hospitals now located in the centers of population at a reasonable distance from all other hospitals and allowing not more than six new locations as planned.

The tragic result of having *too many* small hospitals in the wrong locations means not only unnecessary travel for many patients, their friends, relatives, and the extremely busy doctors, but also an unnecessary investment for the community in duplication of small facilities and less adequate hospital services. It is difficult to attract professional and technical personnel to a facility with a small number of patients. It is true that some of the professional services might be obtained from nearby larger hospitals, and this should be and is being done. Reference is made here to the ordinary routine services which should be performed but might not be in too small a hospital because of cost of adequate diagnostic and therapeutic equipment.

### Size of Area to Be Served Varies

As to the size of population to be serviced, the density of population as it is related to the distance between hospitals is considered. It may be wrong to locate a hospital in an area serving a population of 15,000 if the area is adequately served by a nearby hospital but perfectly logical to establish one in a sparsely settled area of only 10,000 population or less if distance is a real factor. The Commission on Hospital Care concluded that 30 miles, or about one hour's drive in adverse weather, is not an unreasonable distance to obtain adequate hospital care. In Wisconsin the State Plan takes a more liberal attitude by adopting 20 miles, a distance most doctors will not object to travel in sparsely settled areas in order to have better, even though fewer, hospitals. The 60 rural areas in the State Plan contain approximately 1,350,000 people, of whom 73 per cent are distinctly rural. There are 18 areas under 15,000 population, the smallest of which consists of 7,000 people and is sparsely settled; 20 areas contain from 15,000 to 25,000 people; 20 more areas, from 25,000 to 50,000; and only two areas have more than 50,000. Some of the sparsely populated areas have been recognized for the heavy influx of tourist trade as well as the distance to the nearby hospital.

### Rural Areas Show Great Increase in Beds

What have our rural areas been doing about the additional beds needed in their population centers? Some very positive action has been taken by many rural communities to replace, expand, or initiate new facilities. For example, the 60 rural areas need a total of 4,755 beds for adequate service. In 1946, there were 2,149 acceptable beds available, or less than half of those needed, leaving 2,606 beds short. The Hill–Burton Act, under which the Federal Government allocates a limited amount of Federal grants-in-aid to the state for assistance on a matching basis to those communities eligible for and in need of a hospital, made it possible to construct 1,131 of the beds needed. These beds, together with construction of 443 beds outside the Act, give the rural areas 78 per cent of the needed beds, which matches the state average. There remain several dispersed areas in rural Wisconsin which continue to need additional beds; however, for the most part, hospitals recently completed or under construction and those in final planning stages have made a tremendous cut into the *critical* shortages which existed in rural areas prior to 1947. As a matter of fact, if someone had predicted this progress back in 1946, he would have been called an idealist or a dreamer.

### Hospitals Are Expensive

It does not always follow that a community in need of a hospital can afford one.

*(Continued on page 345)*

# THE MEDICAL FORUM

# CATASTROPHIC INSURANCE POLICY TO BE READY IN JULY

**THE FIRST SHOVEL OF DIRT is turned by Dr. E. M. Dessloch, Prairie du Chien, president of the State Medical Society's Realty Corporation, at ground-breaking ceremonies May 12, prefacing construction of the new office building. Shown left to right, Dr. J. S. Supernaw, Madison; Robert B. L. Murphy, Madison, attorney; Anthony Grignano, Madison, general contractor; Dr. Dessloch; Donald E. Gill, Madison, accountant; Dr. Nels A. Hill, Madison, treasurer of the SMS Realty Corporation. Dr. H. E. Kasten, Beloit; and Allen Strang, Madison, architect.**

## Ground Is Broken For New SMS Office Building

Madison, May 13.—The official ground-breaking ceremonies for the new State Medical Society office building on Lake Monona took place the afternoon of May 12.

Present were the officers of the SMS Realty Corporation—Dr. E. M. Dessloch, Prairie du Chien, president; Dr. H. Kent Tenney, Madison, vice-president; Dr. N. A. Hill, Madison, treasurer; and C. H. Crownhart, Madison, secretary.

All councilors and officers of the society are likewise members of the Realty Corporation.

Also present were Dr. H. E. Kasten, Beloit and Dr. J. S. Supernaw, Madison, members of the executive committee of the Commission on Prepaid Plans; Dr. F. L. Weston, Madison, SMS treasurer; Dr. T. W. Tormey, Jr., Madison, secretary of the State Board of Medical Examiners; Dr. Carl N. Neupert, Madison, State Health officer; and various members of the State Medical Society staff.

The lot has now been cleared of trees and brush, and the grading completed. The location of the building has been staked out and work on the foundation begun. The building is supposed to be ready for occupancy by June, 1955.

## Badger Students Named To Student AMA Council

Chicago, May 7.—Two Wisconsin medical students were selected as members of the executive council of the Student American Medical Association at its convention in Chicago the first week in May.

They are David J. LaFond, Green Bay, a student at the Marquette University School of Medicine, and Eugene L. Weston, Baraboo, who attends the University of Wisconsin medical school. Both are juniors.

## Council Also Approves New "All Star" Rider With Five Elements

Madison, May 18.—Plans for a "catastrophic illness" insurance policy developed by the Council on Prepaid Plans were approved by the Council of the State Medical Society at its meeting in Wisconsin Rapids May 15 and 16.

The plans as they are now drawn provide 100 per cent coverage for professional services rendered by physicians participating in Wisconsin Physicians' Service, and 80 per cent of coverage for the services of non-participating physicians. Coverage will be up to $5,000 per person or $15,000 per family for any one accident or illness.

The catastrophic policy will also pay 80 per cent of ambulance transportation or public transportation to the treatment center, and 80 per cent of any non-professional treatment needed in x-ray, laboratory, or physical therapy work, and 80 per cent of any dental services made necessary by an illness which is being treated by a physician.

### Nursing Care Included

Eighty per cent of special nursing care, blood or plasma, drugs and medicines, appliances, and rental fees for equipment such as iron lungs, will also be provided.

All 80 per cent items of coverage must be provided under physician prescription or direction.

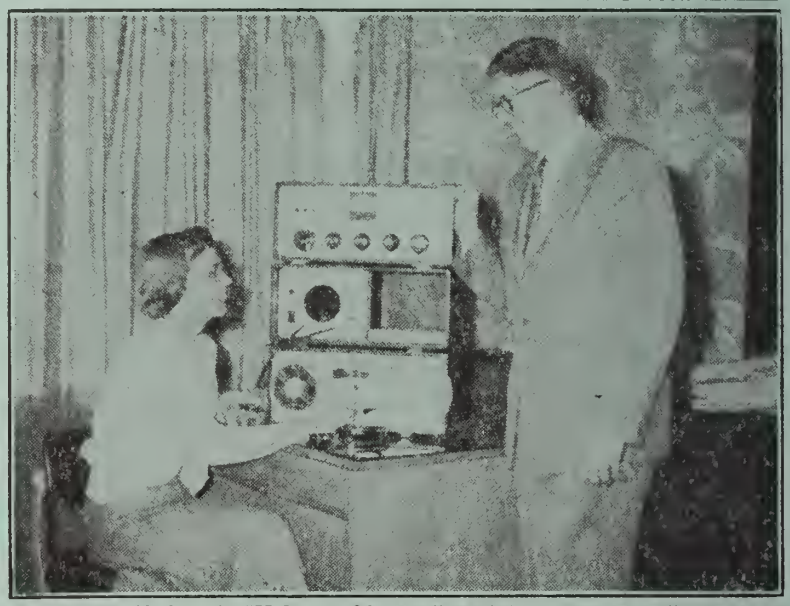
The Council also approved an "All-Star" rider which is to be used with the basic Blue Shield contract on an experimental basis. This rider will include coverage for dental surgery, first day surgery for the newborn, x-ray and radium therapy, diagnostic work-up, and home and office medical calls.

The Council approved a request by the Council on Medical Service that it be allowed to invite the AMA Council on Rural Health to meet with it and invited guests

*(Continued on page 342)*

# HEALTH EDUCATION PROVIDED BY "MARCH OF MEDICINE"

What does the State Medical Society do for its members? This is the seventh in a series of articles which explain the services of the society to the physicians who belong to it.



DR. ROBERT C. PARKIN and his staff assistant test a radio tape on the tape recorder.

Of real public relations significance to the State Medical Society is the radio program "The March of Medicine" which is presented each week over 40 Wisconsin radio stations and two stations just across the border in other states.

The programs, which are fifteen minutes long, reach an estimated listening audience of 300,000 each week. They are programs of the interview type, featuring Dr. Robert C. Parkin, coordinator of postgraduate education at the University of Wisconsin Medical School, who has a knack for putting medical information into understandable language. Dr. Parkin is interviewed by Paul Davis, Medical Reporter, whose part is taken by Myron Curry, a WHA professional.

### Produced in Office

Though the programs are recorded and the record is duplicated onto tapes at station WHA, the production of the program takes place in the State Medical Society office.

Dr. Parkin and his assistant, who is a member of the medical society staff, keep their production about eight weeks ahead of the first airing of a new script. They start by deciding upon subject matter. They have dealt with about 100 subjects to date. Certain ones are repeated each year at the appropriate time of year—polio in July or August, upper respiratory infections in the late fall, and so on.

### Subjects Limited

Choice of subject is limited by three factors, One is time. Fifteen minutes is not long enough for comprehensive discussion of certain subjects. Another is familiarity. The programs do not deal with medical rarities and diseases which have jaw-breaking names that mean nothing to the average listener. The third is technicality. The programs are always couched in terms understandable to the layman, and that, in itself, rules out many medical subjects.

Once the subject is decided upon, Dr. Parkin dictates for about 15 or 20 minutes, presenting the information he wants to have used. The record of his dictation is delivered to his assistant in the State Medical Society office who transcribes it verbatim. From this transcript and some outside reading of authoritative subjects, she then works up a two-man script of the proper length. It is typed in final form, and a copy goes to Dr. Parkin for his final O. K.

### Recording at WHA

This done, a recording date is set, and Dr. Parkin meets Myron Curry at station WHA where the recording is completed. Usually, two scripts are recorded at one sitting.

From the master recording, fifteen tapes are "dubbed." These are returned to the assistant at the medical society office who checks them on the society's tape recording machine for correctness and timing. After this final check, announcer scripts and cue sheets are written, to be mailed with each individual tape. Each tape is then labeled and placed in circulation.

Every subject which is recorded eventually reaches every station which carries "The March of Medicine." After every station has been covered, the tapes of that particular subject are erased and used for another recording. The society owns, in all, about 250 tapes which can be used and reused an indefinite number of items.

### Questions Invited

The announcer scripts invite the listening audience to write for copies of the programs or direct personal letters to Dr. Parkin if they have any questions. During the winter, 500 to 600 pieces of mail are received, and in the summer, the number drops to around 300. About two thirds of these are requests for mimeographed copies of the scripts, and the other third are personal letters which are forwarded unopened by the radio stations.

Dr. Parkin personally provides the answers to every letter requesting advice on any personal health problem. Every effort is made to retain the confidentiality of these communications in keeping with established patient-doctor relationships.

"The March of Medicine," is carried as a public service feature by all the 42 stations. In other words, the stations donate the time

## AMA HAS PUBLIC RELATIONS GUIDES FOR PROGRAMS OF LOCAL SOCIETIES

Madison, Feb. 12.—Every medical society must scrutinize its own problems and develop a public relations program pared to fit its own local needs.

But the American Medical Association has some public relations guides which may help a county medical society in reaching a good public relations goal.

### Three Major Points

The American Medical Associations offers a "three–D" program in public relations:

1. Develop a stronger, more unified profession by planning society indoctrination programs for new members, increasing society participation by placing new members of committees and society activities, and studying all medical issues so as to provide an informed profession, particiularly with regard to the stand of the American Medical Association on issues of national scope. Society and individual community participation should be increased, material should be made available on all kinds of socio-economic subjects and public relations, and every effort must be made to reduce the evils of professional jealousy and unwarranted criticism of one MD by another since such actions harm all doctors in the eyes of the public.
2. Utilize all public relations outlets to tell medicine's positive story. This can be done by presenting radio and TV programs locally, sponsoring health forums in cooperation with newspapers, developing good press cooperation and suggesting ideas for local features on medical subjects, activating a society speakers bureau, preparing leaflets describing local medical facilities for newcomers, placing medical exhibits at fairs and public gatherings, and utilizing the potential of the Woman's Auxiliary in carrying out society projects.
3. Mend public relations fences by eliminating complaints about medicine. Every effort should be made to maintain and improve high standards of medical practice so as to eliminate the few unethical MDs who may damage the reputation of the whole profession. The community should have a working, well-publicized night and emergency telephone call system.

The AMA also encourages establishment of medical audit and tissue committees in hospitals to combat widespread publicity regarding unnecessary surgery and the like. Physicians everywhere should promote voluntary health insurance and develop better understanding about such insurance programs.

## No Grants to Scientists Of Questioned Loyalty

Washington, April 30.—The Department of Health, Education and Welfare has confirmed that Public Health Service research grants have been denied or withdrawn from 30 scientists since 1952 on grounds of alleged subversion or disloyalty. A department spokesman said the agency felt "it was not in the best interest of the United States" to issue the grants even though the projects being worked on were not secret or classified. The department gave no breakdown of the sciences involved.

to the cause of health. Broadcast time on the various stations therefore depends upon the available free time which the radio stations have, and Saturday is the day it is most often scheduled.

An off-shoot of "The March of Medicine" is the tape recording loan service which was inaugurated to assist teachers in disseminating authentic health information to high school students.

Ten of Dr. Parkins broadcasts were selected for this purpose, and five tapes were made of each subject. Study guides were prepared for each one, along with copies of the script. Then brochures telling of the availability of these tapes were circulated to every high school and junior high school in the state. The tapes were listed for use in physical education, health education and physiology classes. The response has been good. Approximately 60 tapes go out each month.

From the material Dr. Parkin provides for radio scripts, his assistant prepares a short article for him which appears in the Wisconsin Agriculturist and Farmer twice a month. These articles, again, focus attention on the need for getting advice from the family physician.

Work has been started on a television program which is to be presented initially over WHA–TV. A pilot program, on the subject of diabetes, is to be kinescoped for several preliminary showings. The first TV programs will be 15-minute presentations, and will be televised on WHA–TV until some regular basis for production and possible state-wide distribution can be worked out.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# By-Laws Changes for House of Delegates Ready to Be Presented at Next Session

Madison, May 14.—Several changes in the By-Laws governing meetings of the House of Delegates have been approved by the Council. They have also received the approval of a joint meeting of the Interim Committee with the officials of the House of Delegates. The proposed changes are as follows:

1. A By-Laws resolution would be offered to the House of Delegates, requiring each county society to elect its delegates and alternates to serve a term of at least one calendar year, and in any event, that the term of office expire on December 31 of a particular year. This is consistent with the pattern of the AMA and means that no matter when a delegate is elected, he takes office on the following January 1 and serves through December 31 of the year in which his term expires.

2. It would be a standing rule of the House of Delegates that whoever is seated to represent a county medical society serves as delegate for the entire session, with the privilege of the elected alternate, however, being seated at any subsequent session, upon recommendation of the Credentials Committee.

3. Credentials would be distributed directly to delegates, rather than being routed through the county secretary as is done at present.

4. Those registering for attendance at the House of Delegates, other than as voting delegates would be provided with special registration slips.

5. The present by-law providing that the number of delegates to which a county society is entitled shall be determined by the number of fully paid members 30 days in advance of the first session of the House of Delegates would be changed so that such determination would be made by the number of paid members at the close of the prior fiscal year.

6. The Credentials Committee would be seated at the registration table to handle such problems as may arise.

All of these proposals, designed to shorten and simplify procedures during registration at the Annual Meeting, will be put to a vote by the House of Delegates at the next session.

## MDs, Editors, Lawyers All Make Mistakes But With Different Results

(From the Brodhead Independent-Register for April 29, 1954)

I don't know how newspapers got into the world, and I don't think God does, for He never mentions them in the Bible. Maybe the editor was one of the Fallen Angels, for he seems to fall for about everything people tell him.

If the editor makes a mistake, folks say he ought to be hung; if a lawyer makes a mistake he appeals the case; when a doctor makes a mistake they say nothing 'cause they don't know Latin and they couldn't read his writing if they did.

An editor makes a mistake, there's a lot of hollering, cussing and a libel suit, while when the doctor makes a mistake, there's a funeral, with flowers and silence, perfect silence.

A doctor can use a word a mile long and it won't make any difference if he knows what it means, for folks will think he's educated, while an editor has to be able to spell any word he uses. If a doctor goes to see another man's wife, he charges for the visit, while if the editor goes, he gets shot.

People that call the doctor and get well think he's a great man. If they don't get well, they're dead and can't say anything. Two-thirds of the folks in town are sore at the editor either because the paper said something about them they didn't like, or said something nice about somebody else.

# AMERICAN ACADEMY FORMS NEW CHAPTER IN NORTH WISCONSIN

Wausau, May 1.—A group of 35 physicians from northern Wisconsin met in Wausau late in April to organize the North Wisconsin Chapter of the American Academy of General Practice.

Officers elected were Dr. A. H. Stahmer, Wausau, president; J. W. Lambert, Antigo, vice-president; and James J. Leahy, Park Falls, secretary-treasurer.

Committee chairmen will be Dr. D. M. Green, Wausau, luncheon; Dr. Charles M. Balliet, Wausau, publicity; Dr. A. W. Hoessel, Wausau, hotel and housing; and Dr. Lambert, membership.

Other members of the Northern Wisconsin Chapter are Drs. William A. Knoedler, Mosinee; G. J. Bachhuber, Athens; C. J. Picard, Superior; C. C. Newman, Wittenberg; J. Leahy, Park Falls; W. P. Curran, Antigo; G. H. Handy, Wisconsin Rapids; Francis Lane, L. J. Bayer and Walter Lewinnek, Merrill; and George R. Hammes, E. E. McCandless, H. H. Fechtner, T. C. Burr, D. J. Freeman, Fred C. Prehn and S. M. B. Smith, Wausau.

The group is planning a symposium of scientfic interests to be held in Wausau June 25 which is expected to draw about 450 physicians from Wisconsin and neighboring states.

# TEST PHYSICAL EXAM CAMPAIGN IN TREMPEALEAU

Madison, May 18.—The Wisconsin Press Association has agreed to assist the physicians of Trempealeau County in a campaign for promoting periodic health examinations among the people of that county.

This promotion is to serve as a test program in a general scheme for furthering better health practices throughout the state, through cooperation between the Press Association and the medical profession.

A recommendation that this program be carried out received the approval of the Council on Medical Service which passed it along to the Council. The Council has also approved.

It is understood that the fee to be charged for the physical examination is to be left up to the individual physician unless, among themselves, the physicians agree to a specific charge. The fee to be charged in Trempealeau County in no way commits physicians in other parts of the state to charge a similar fee under a similar program.

Dr. R. L. MacCornack, Whitehall, and Dr. W. J. Fencil, Monroe, were the physician members of the joint committee which worked out details of the program.

# HEARING CONSERVATION GUIDE READY FOR PRODUCTION

Madison, May 17.—A guide containing recommendations for hearing conservation programs for Wisconsin industries was approved by the Council of the State Medical Society at its May meeting in Wisconsin Rapids.

The guide was prepared by a special committee of the State Medical Society in cooperation with the Industrial Hygiene Division of the State Board of Health, the Wisconsin Industrial Commission, the Industrial Nurses Section of the Wisconsin State Nurses Association and the Wisconsin Council of Safety.

### Dr Tolan Chairman

**Members of the special committee are Doctors T. L. Tolan, chairman; Meyer S. Fox and Paul J. Whitaker, all of Milwaukee; George Nadeau, Jr., Green Bay; L. C. Gardner, Fond du Lac and C. E. Taborsky, Madison.**

The guide starts with a group of pertinent facts arising from the best knowledge available. It is known that hearing loss caused by noise may be temporary or permanent, that permanent injury to the inner ear is not amenable to any treatment now known, and that some ears are more susceptible to injury than are others. It is known that apparatus is available to measure hearing loss, and that noise levels which damage the ear can be reduced by engineering methods and by ear protection.

### Critical Noise Defined

Generally speaking, it can be said that any environment which prevents the hearing of loud conversation at arm's length suggests the need of some protection from or reduction of noise.

The basis of the hearing conservation program is that of giving an audiometric test to each new employe who is to work in a noisy area, and to recheck after thirty days. If any change in the worker's acuity is noted at this time, serious consideration should be given to removing the individual from the high noise area. If no change is noted, retesting should be done again every six months.

**In order to provide a list of specialists who can take charge of testing programs, the State Medical Society has polled all eye, ear, nose and throat men to determine whether they wish to be listed in a panel of those participating in the hearing conservation program. This list will be available annually.**

DR. T. L. TOLAN

To be listed on it, the physician must have proper auditory testing equipment, be available for appointments requested by industry, and agree to file the necessary medical reports with the employer in all cases.

### Fees by Agreement

The guide suggests that the fee for the services of the otologist to industry should be determined in each area by agreement between the specialists and the plants.

The final conclusion is that the ideal hearing conservation program consists of eliminating or reducing the noise at its source, and providing ear protective devices to all who work in areas where the noise cannot be reduced to a safe level.

**It is proposed that about 5,000 copies of the guide be printed initially, with distribution through a special mailing to all Wisconsin industries of sufficient size to suggest the need for such a program. It is anticipated that there will be great demand for this guide from industries outside of Wisconsin, as we are leading the way on this important industrial problem.**

Financial assistance in covering the printing costs is expected from the Industrial Hygiene Unit of the State Board of Health, interested associations of plant management, and insurance carriers.

## Two New Pamphlets on Civil Defense Available

Chicago, June 2.—The part the physician should play in civil defense is plainly and skillfully shown in a series of six articles which the AMA's Council on National Emergency Medical Service is offering in booklet form.

Reprinted from the *Journal* of the AMA, these articles discuss such aspects as organizing for civil defense, developing medical participation, physician's responsibilities, and the doctor and the improvised hospital.

In addition, the Council now has available the "Proceedings of the Medical Civil Defense Conference" which was held in Louisville in February. This should prove a valuable sourcebook inasmuch as it contains thorough discussions of atomic bombing, the threat of biological warfare, civil defense against chemical warfare, psychological warfare and a case study of a typical state's civil defense organization.

Both booklets may be secured without charge from the State Medical Society.

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## SOCIAL SECURITY COMMITTEE OF CHAMBER REVIEWS HEALTH, WELFARE LEGISLATION

Madison, June 4.—C. H. Crownhart, Madison, secretary of the State Medical Society, is co-chairman with L. R. Wheeler, Milwaukee, of one of the subcommittees of the Social Security Committee of the Wisconsin State Chamber of Commerce.

It is the function of the Social Security Committee to follow all state and federal legislation in the welfare field, and recommend proper policy in regard to it to the Chamber's board of directors. Occasionally this committee will suggest that local chambers be urged to write to Washington in support of or in opposition to a certain bill.

The subcommittee on sickness, health and disability headed by Mr. Crownhart and Mr. Wheeler also includes S. L. Horman, Milwaukee; H. E. Scherer of the Monroe Clinic, Monroe; J. S. Clowes, Milwaukee; D. Snoyenbos, Milwaukee; F. J. Hughes, Milwaukee; H. J. Rafferty, Kenosha; W. B. Peters, Racine and M. A. Buntrock, Kenosha.

### Other Subcommittees

Mr. Crownhart is also a member of the subcommittee on workmen's compensation which is headed by M. P. Verhulst, Madison and H. R. Chipman, Racine. Other members are F. W. Kerscher, Manitowoc; D. C. Dean, Two Rivers; R. F. Fisher, B. A. Krawczyk, E. L. Cling and Mr. Wheeler, Milwaukee; M. J. King, Racine; Mr. Scherer, Monroe and A. L. Klein, La Crosse.

The subcommittee on unemployment compensation is headed by Mr. Krawczyk and Mr. Clowes. Other members are Mr. King and R. G. Erickson, Racine; P. M. Chiuminatto, Green Bay; Mr. Fisher, Mr. Cling and J. L. Whittet, Milwaukee; H. F. Moller, Janesville; W. R. KasaKaitas, Madison and Mr. Rafferty and Mr. Buntrock, Kenosha.

A fourth subcommittee is on old age and survivor's insurance and is headed by Mr. Hughes and J. W. Joanis, Stevens Point. Other members include W. F. Kurfess and R. G. Collins, Milwaukee; L. H. Eckhardt, Baraboo and Messers Dean, KasaKaitas, Kerscher, Chiuminatto, Klein, Chipman and Verhulst.

Other members of the Chamber's Social Security Committee are C. N. Jacobs, Stevens Point; F. A. Sinkewicz, Clintonville and J. C. Fagan, Madison.

### *REPRINTS OF "DON'T KILL YOUR DOCTOR" GOOD FOR MAILING*

"Don't Kill Your Doctor," is the name of an excellent short article which appeared in *The Rotarian* for December, 1953.

It briefly explains the doctor's dilemma—to go or not to go when called in the middle of the night by an hysterical person who is sure that whatever illness has appeared in the family is a serious matter that cannot wait 'til morning.

It also advises the patient to line up a family doctor who, through knowing him, will know whether his alarm is warranted.

Reprints of this article cover only one side of a single sheet which folds to 3½ by 5 inch size, making it just right for a letter enclosure.

Physicians who would like a quantity of these reprints may order them without charge from the State Medical Society, Box 1109, Madison.

## Doctors Take Part in Slow Learner Institute

Milwaukee, May 9.— A number of Wisconsin physicians took part in the fourth annual Institute on the Slow Learner in Milwaukee May 8.

Dr. H. Kent Tenney, Madison, president of the State Medical Society; and Dr. Leslie A. Osborn, Madison, were morning speakers. The keynote address was given by Dr. Clemens E. Benda, director of research and clinical psychiatry at the Walter E. Fernald State School, Waverly, Mass.

Physicians who took part in the seven special interest workshops included Drs. Thorsten Smith, Chippewa Falls; Francis J. Millen, R. C. Waisman, Samuel E. Kohn, David J. Zubatsky, all of Milwaukee; J. S. Vedder, Marshfield; and Henry I. Okagaki, John W. Doolittle, Gwen Arnold, Maxine Bennett and Robert E. O'Connor, all of Madison.

## Conferences on School Health Draw 250 Each In Eau Claire, Oshkosh

Madison, May 15.—About 250 people attended each of two regional conferences on school health sponsored by the State Medical Society in cooperation with the State School Health Council recently.

The first of these took place in Eau Claire April 7, and the second May 13 in Oshkosh, each of them at the local state college. Two more conferences are planned for fall, one to take place in Stevens Point in October and one in La Crosse in November.

Dr. E. H. Pawsat, Fond du Lac, chairman of the society's Division on School Health, presided over the morning sessions at both conferences and teamed up with Dr. H. Kent Tenney, Madison, society president; and Dr. Edgar S. Gordon, Madison, of the University of Wisconsin Medical School, to present an evening symposium on 'Why Children Grow and Parents Groan."

Physicians who took part in the discussion groups at the Eau Claire meeting were Drs. Clifford Olson, Baldwin; Herbert Dasler, Amery; Rex E. Graber, Chippewa Falls; O. G. Moland, Augusta; A. A. Lorenz, Eau Claire and Walton Manz, Eau Claire.

Those who took part in the Oshkosh discussion groups were Drs. Donald H. McDonald, Winneconne; George Shinners, Green Bay; William B. Hildebrand, Menasha; Melvin Apell, Oshkosh; H. J. Kief, Fond du Lac; Robert O'Connor, Madison; Keith Keane, Sheboygan; and Marvin Steen, Oshkosh.

## INSURANCE . . .

*(Continued from page 337)*

for the initial planning session of the National Rural Health Conference to be held in Milwaukee February 24 through 26, next year.

An invitation to become a Charter Member of the newly reorganized Wisconsin Public Health Council was accepted by the Council in behalf of the society as a whole.

The Council on Medical Service asked the society's Council for authority to issue a public statement in the name of the medical society endorsing the use of safety belts in automobiles, particularly in the right front seat.

## TWO DIVISIONS HOLD JOINT MEETING TO STUDY HEARING, SIGHT CONSERVATION

Madison, May 10.—Twenty-eight counties are carrying out screening tests in their schools in accordance with the hearing conservation program of the Bureau of Handicapped Children.

Joseph Marks of the State Department of Public Instruction reported on the program at a joint meeting of the Division on Hearing and Visual Defects and the Division on Crippled Children of the State Medical Society's Commission on State Departments held May 9 in Madison.

### Eleven MD's Present

Physicians present at the meeting included Drs. Maxine Bennett, John Doolittle and C. G. Reznichek, Madison; Howard High, Milwaukee; E. G. Nadeau, Green Bay; S. B. Russell, Eau Claire; and E. J. Zeiss, Appleton, all of the Division on Hearing and Visual Defects; H. A. Sincock, Superior; J. W. Nellen, Green Bay; R. C. Waisman, Milwaukee; and A. B. Weinstein, Madison, all of the Division on Crippled Children.

Mr. Marks explained that the otologist who is in charge of the hearing conservation clinic at the school sends a report to the school, one to the family, and one to the family physician of each child tested. The public health nurse follows up.

### Time Limit Suggested

Dr. Sincock suggested that a definite time limit for seeing the family doctor or the otologist be entered in the report, so that the matter will not be allowed to slide.

Dr. Reznichek, who is president of the Wisconsin Academy of General Practice, stated his eagerness to see that general practitioners cooperate fully in the program. A possible education program aimed at this would include a display of equipment and a demonstration of audiometric testing at the next annual meeting of the Academy.

Frank Powell of the Department of Public Instruction expressed a need for more professional education on audiometric testing and suggested that a guide sheet be prepared which could be sent to each physician in the county where a screening program is scheduled. Dr. Bennett, chairman of the Division on Hearing and Visual Defects, will work with Mr. Marks and Mr. Powell to prepare such a guide.

E. L. Hoskins of the State Department of Public Welfare discussed the state program for the blind, which places special emphasis on rehabilitation. He said that the greatest help physicians could render his agency would be that of making the state services for the blind known to people with visual loss and getting them into the hands of workers so that individual cases can be studied as early as possible.

It was also suggested that the state services be made known to resident physicians in hospitals and to physicians newly licensed to practice in Wisconsin.

Dr. Doolittle also stated that a special committee of the State Medical Society had met recently with representatives of the Motor Vehicle Department and were prepared to recommend a "profile" type of screening examination connected with licensing rather than a re-examination on the basis of age.

A guide for a rheumatic fever program was approved with the provision that is be sent out with a covering letter emphasizing that it only offers a general pattern and is not the only approach to the problem.

## AUXILIARIES GIVE TO EDUCATION FUND

Madison, May 19.—A total of $915. has been contributed by woman's auxiliaries to county medical societies to the coffers of the American Medical Education Foundation.

Auxiliaries which have made contributions to date are Milwaukee, Dane, Polk, Rock, Outagamie, Fond du Lac and Green Lake-Waushara. Mrs. L. O. Simenstad, Osceola, is state chairman.

Anyone wishing to honor a deceased friend or relative may make a contribution to the Foundation in memory and send a card to the family. Sample memorial cards have been sent to each county auxiliary, and the use of them is not limited to doctors and their families. It is suggested that they tell interested friends about this very worthy use for memorial money.

## Subcommittee Studies Recommended Changes In Commitment Laws

Madison, May 11.—An amendment to existing laws governing the commitment of patients to mental institutions which would make it clear that mental examinations need not take place in open court or in the presence of the judge was proposed at the meeting of the Subcommittee on Commitment Laws of the Division on Nervous and Mental Diseases when it met in Madison May 10.

### Physicians Attend

Physicians who attended the meeting were Drs. Walter J. Urben, Madison; E. D. Schwade, Milwaukee, and Henry Veit, Milwaukee.

Another proposed amendment would exclude the physician from being one of the petitioners on an application for the temporary detention of a patient. The physician must certify such an application, however.

An amendment ruling out a city or county jail as a place for temporary detention of a disturbed person had been suggested at a former meeting. A communication from Juneau County Judge William R. Curran, Mauston, told the committee that this would work a hardship on rural areas.

### Might Circumvent Purpose

There, rather than incur the expense of immediately transporting a patient to a state institution from which he would have to be brought back for a hearing, county authorities might not detain him at all, and the whole purpose of temporary detention would be circumvented. It was therefore decided that a jail can be used if the judge is satisfied that in it the disturbed patient can be isolated from contact with other prisoners.

Existing law authorizes the county board to set the fee for the services of examining physicians, but the pay is limited to the physician's attendance at the hearing. The committee agreed that authorization should be extended to include the physician's examination and other services.

# AMA SURVEYING MD'S BACK FROM MILITARY DUTY

Chicago, May 20.—With a view to improving the utilization of medical personnel in the armed forces and formulating a more effective voluntary officer procurement system, the AMA's Council on National Emergency Medical Service has been conducting a survey of physicians leaving active military service.

Results of the first year's survey are carried in a report recently issued by the council. From July 15, 1952 to August 1, 1953, 3,948 completed questionnaires revealed that the average time spent in service was 24.7 months; average tour of duty in the U. S., 7.6 months; average tour of foreign duty, 17.1 months.

### Approve Distribution

A total of 29 per cent felt there was overstaffing; 20 per cent thought the military was understaffing, and 51 per cent thought the distribution of medical personnel was adequate. Of those assigned to domestic duty, 53.4 per cent were engaged in treating military personnel, 28.3 per cent in treating military dependents, and 18.3 per cent in "other."

Of those assigned overseas, 51.8 per cent treated military personnel, 23.8 per cent dependents of military personnel, and 24.4 per cent "other." Answers to the question regarding the type of medical care provided for other than military personnel indicate that in the Army and Navy, the most frequent type was outpatient care, while in the Air Force it was obstetrics and gynecology.

### Medical Societies Help

The following activities were suggested in answer to a question about how local and national medical associations can better serve their members in service; more information via a newsletter; personal visits by civilian doctors to evaluate grievances; invitation of military doctors to civilian medical meetings; assistance in locating a position after discharge; assistance in preventing evasion of military service; distribution of questionnaires to physicians in service; provision of specialists for clinical conferences.

## *YOURS FOR THE ASKING*

The AMA announces a new series of four pamphlets produced as a service to state and county medical societies and their members:

"Why Wait" urges selection of a family doctor before illness strikes.

"On Guard" explains the AMA's role in the testing of new drugs and medicines.

"Health Today" shows how research has contributed to longer lives.

"Quack" warns against cults of pseudo-healers.

A copy of each is to be distributed to every medical society member soon.

These pamphlets, 6½ x 3½ inches in size, are suitable for mailing. They can also be placed in reception rooms or distributed at meetings and forums. They are available in quantity without charge from the State Medical Society.

# AMA Helps "Strike It Rich" Program Check on Medically Needy Cases

Chicago, May 13.—With the purpose of asking for a closer check on some of the medically needy "heart-break" cases which appear on the "Strike It Rich" television show, AMA Public Relations Director Leo Brown and Robert Potter, executive secretary of the Medical Society of the County of New York, called on Walter Framer, producer of the program.

Mr. Framer made it clear that he has no desire to discredit the medical profession and is eager to cooperate with it. He asked the AMA to check up on two cases.

An appeal had been made in behalf of one family which had accumulated a total medical bill of around $6,000. On investigation, it was found that the family was covered by Blue Cross, that the doctor and the patient had discussed the fees and had a complete understanding, and that at no time had the patient been without medical care for financial reasons.

The second case involved a boy of 16 who had been blind since birth and wished to appear on the program in order to obtain sufficient funds for a comprehensive examination of his infirmity. Investigation revealed he had had repeated examinations by the chief of ophthalmology at one of the medical schools, and had long been attending a state school for the blind.

In both cases it was apparent that the patient had been properly cared for at the community and state level. When this information was made available to Mr. Framer, he considered both cases ineligible to appear on his program.

# Medical Civil Defense Conference Precedes AMA Meeting in June

Chicago, May 21.—Dr. James C. Sargent Milwaukee, is chairman of the AMA Council on National Emergency Medical Service which is planning an all-day conference on civil defense to be held in San Francisco June 20, the day before the opening of the AMA annual meeting.

The conference will take place at the Palace Hotel starting at 9:30 with Dr. Stafford L. Warren serving as chairman. The theme will be "What Can the Doctor Do" in civil defense.

The talks will include the following subjects: "The Problem of National and State Civil Defense—What Can the State Directors Do?", "The Local Problem and Mobile Support", "Patient and Doctor Relationship During Emergencies", "Panic During Disaster", "The Federal Civil Defense Medical Program", "Plan for Airbone Hospitals for Disaster Emergencies," and "What Have Our Medical Societies Done."

# EVEN THE INDIANS ARE AFTER US NOW

Chicago, June 6.—The Potawatomi Indians, who put down their tomahawks in 1812, have been fighting legal battles ever since to be paid for the valuable real estate of which they claim they were deprived by U. S. agents who used undue influence, persuasion and threats—not to mention large quantities of fire water.

They are now fighting for $8. an acre for 1.4 million acres of land on which downtown Chicago is now located. This includes the present site of the AMA building.

TABLE 1—*Comparison of General Hospitals and Beds—1952 and 1946*
*State of Wisconsin**

| Area | GENERAL HOSPITALS AND BEDS | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Acceptable | | | | | | | | Replaceable | | | | | | | |
| | Number of Hospitals | | | | Number of Beds | | | | Number of Hospitals | | | | Number of Beds | | | |
| | 1952 | 1946 | + or — | Per Cent | 1952 | 1946 | + or — | Per Cent | 1952 | 1946 | + or — | Per Cent | 1952 | 1946 | + or — | Per Cent |
| Entire State | 129 | 100 | +29 | 29% | 12,355 | 9,322 | +3,033 | 33% | 42 | 84 | —42 | —50% | 952 | 1,208 | 256 | —21% |
| Base Areas (2)[1] | 18 | 16 | +2 | 13% | 3,830 | 3,169 | +661 | 21% | 8 | 6 | +2 | 33% | 256 | 211 | +45 | +21% |
| Intermediate Areas (13)[2] | 32 | 31 | +1 | 3% | 4,802 | 4,004 | +798 | 20% | 3 | 6 | —3 | —50% | 42 | 59 | —17 | —29% |
| Rural Areas (60)[3] | 79 | 53 | +26 | 49% | 3,723 | 2,149 | +1,574 | 73% | 31 | 72 | —41 | —57% | 654 | 938 | —284 | —30% |

*Prepared by State Board of Health Division of Hospital and Related Services, January 1954.

[1]Base areas must contain a teaching hospital of a medical school or a population of at least 100,000 and one or more general hospitals with a bed complement of 200 or more beds for general use. The hospital must furnish internships and residencies in two or more specialties.

[2]Intermediate areas must contain a population of at least 25,000 and at least one general hospital of 100 or more beds (preferably 150 beds) suitable for a district hospital in a coordinated hospital system within the state.

[3]A rural area shall constitute a unit no part of which has been included in a base or intermediate area and which is so designated by the state agency.

Construction costs have remained so high that many communities are not able to construct more than a minimum number of beds, even though Federal grants-in-aid provide a substantial portion of the required funds for the project. For 13 new initial hospitals completed in rural areas, the average cost for a 32-bed hospital expandable to 39 beds is $525,000, or from $13,000 to $16,000 per bed for a fully equipped hospital ready to start operations.

Many of the hospitals started with an indebtedness of approximately 20 per cent of the original total cost. Although the Federal Act allows an indebtedness up to one-third of the total cost of the facility, many authorities on hospital finance recommend that not more than 20 per cent be taken on as a burden by most voluntary hospitals. Communities without hospitals will want to reexamine their desires in terms of these sober figures.

### How Many More Hospitals Do We Need?

To answer the question of how many additional beds or hospitals are needed for rural areas, it is necessary to study the demand still to be satisfied for the state as a whole. Table 1 indicates that the total number of acceptable and replaceable hospitals in rural areas has been reduced from 125 to 110, but the important change is that 41 of the replaceable facilities have been exchanged for 26 new modern hospitals, *and* the real news lies in the fact that practically all of these changes for the better occurred in the rural areas.

The increase of 1,574 new beds and 26 new hospitals in rural areas is no more gratifying than the elimination of the 41 small nonfire-resistive facilities which previously contained 284 beds. Most of the remaining 654 replaceable beds will also be eliminated within the next two years by more new construction.

So far we have been discussing factors involved in the overall need for additional beds in rural areas. How does this information apply to the particular community where you live?

1. Ten rural areas need new buildings.

(a) Six of these areas (Crandon, Chilton, Hurley, Wautoma, Eagle River, and Spooner) remain in need of new *initial* hospitals with 150 beds, and even these are not critical areas; that is, adequate hospital facilities are or will be available at a reasonable distance to the majority of the residents in the areas. The six areas have been recognized in a long-range plan as possible centers which may or may not materialize in the near future, depending upon the continued availability of the nearest hospitals.

(b) In addition to the six areas without hospitals, four other communities (Park Falls, Amery, Stanley, and Prairie du Chien) in need of 175 beds, need a replacement of present facilities which, for the most part, are becoming obsolete or were not constructed specifically for hospital use.

(c) Can these ten specific areas in need of approximately 325 beds solve their hospital problem? The opportunity to do so was never greater than it is at the present time.

TABLE 2—*Comparison of Average Daily Census (Occupied Beds) and Patients Admitted—General Hospitals, 1946 and 1952*

*State of Wisconsin**

| AREA | Average Daily Census | | | | Patients Admitted | | | |
|---|---|---|---|---|---|---|---|---|
| | 1952 | 1946 | Increase | | 1952 | 1946 | Increase | |
| | | | Number | Per Cent | | | Number | Per Cent |
| Entire State | 9,852 | 8,488 | 1,364 | 16.1% | 475,723 | 325,069 | 150,654 | 46.3% |
| Base Areas (2)** | 3,366 | 3,097 | 269 | 8.7% | 149,070 | 108,199 | 40,871 | 37.8% |
| Intermediate Areas (13)** | 3,679 | 3,210 | 469 | 14.6% | 176,479 | 121,988 | 54,491 | 44.7% |
| Rural Areas (60)** | 2,807 | 2,181 | 626 | 28.7% | 150,174 | 94,882 | 55,292 | 58.3% |

*Prepared by State Board of Health Division of Hospital and Related Services, January 1954.
**See Table 1 for definition of areas.

Federal grants-in-aid will continue to be available for at least three more years, through the fiscal year 1956–1957, to assist such projects with aid of not less than 33⅓ per cent of the total cost. While appropriations have been reduced for five consecutive years, even the reduced amount will be sufficient to assist all of these ten areas if they choose to take advantage of their favorable priority.

2. If the community now has an acceptable structure, there is probably need for some expansion and perhaps for considerable modernization in the case of some of the older hospitals. There are 15 such rural areas which today have met less than the state average of 78 per cent of their needs. These areas need about 400 beds to satisfy the demand for adequate hospital services. Again, based on our experience in operating the Hill–Burton program, about one-third of these communities will be eligible for Federal assistance during the remaining three years of the program simply because half or more of the ten areas previously mentioned as having a higher priority will not take the necessary action to sponsor the needed project.

3. If your community is among the 25 not recognized in the State Plan as a part of an integrated hospital system and your facility is obsolete or nonfire-resistive, it means that a replacement is not considered absolutely necessary. It may be an unnecessary, expensive duplication of facilities already available or under construction in nearby communities. The 25 communities in question contain 411 beds, or about 16 beds per hospital. All of these hospitals are located less than 20 miles from other acceptable hospital centers. Moreover, almost 200 of the 411 beds are of the replaceable category, the remaining 211 beds in buildings that could be converted into better than average nursing homes, which are increasingly needed in many areas. Of course, it is too much to expect that the communities involved will follow such a plan. There is no law or regulation to prevent the continued operation of the hospitals. The State Hospital Plan merely does not designate such community hospitals as needed in the long-range plan for a coordinated system.

4. If a community does not now have a hospital and is not designated in the State Plan as an eligible hospital center, it probably does not need a hospital.

We are now ready to answer the question, "Does rural Wisconsin need more hospitals?" Rural Wisconsin, with 3,723 beds already available, still needs 1,032 beds to reach the total desirable need of 4,755 beds for the 1,350,000 residents living in predominantly rural areas. Of the 1,032 additional beds needed, more than 70 per cent are required in 25 areas which now have less than three-fourths of the total beds needed. The rural areas as a whole now compare favorably with urban sections. The 60 predominantly rural areas have 78 per cent of the needed beds, exactly the same percentage as the 15 urban areas containing the rest of Wisconsin population. As a result of this fine rural progress, emphasis might very well be placed on urban areas in the immediate future unless the present trend changes.

Finally, it should be strongly emphasized that a system of hospitals developed on a sound basis is bound to provide a more complete service to the patient and the doctor, resulting in a smaller total investment for more and better hospital care facilities for our rural population.

### Admissions Increase Faster Than Bed Occupancy

In Table 2 it will be observed that admissions to all hospitals increased at a much faster pace than the increase in bed occupancy. This has been made possible primarily by the shortened length of stay per patient from about 9.5 days in 1946 to 7.6 days in 1952. While some of this shortened stay occurred because of newer methods of treatment, much of it was due to the shortage of beds which demanded rooms for the acutely ill rather than for convalescent patients.

Table 2 also shows a large percentage of increase (28.7) in the number of occupied hospital beds in rural centers, more than three times greater than the percentage (8.7) in base medical centers and almost twice as great as that in the intermediate hospital centers. However, it should be emphasized that the important base medical centers, particularly Milwaukee, have been operating their hospitals at the maximum capacity, there being little chance to increase bed occupancy. For instance, base area admissions have increased 37.8 per cent, whereas bed occupancy increased only 8.7 per cent. This indicates not only a *forced* shorter length of stay but also the heavy pressure for beds. Incidentally, beds will become more readily available in the near future after the completion of planned expansion programs amounting to many millions of dollars in such areas.

### Hospitals and Related Facilities

Of special interest to the rural population is the large number of projects and beds which were approved for their areas. Table 3 shows that over 14½ million dollars, or 75 per cent of Federal funds, were used for 38 general hospital projects. Thirty-six of the projects went to rural areas. These rural projects absorbed over $8,000,000 in Federal grants. While this constitutes 64 per cent of *all* the Federal funds allotted to Wisconsin during the past seven years, it represents 85 per cent of all Federal funds used in Wisconsin for general hospital construction. These 36 rural projects will provide from 1,131 to 1,364 beds, practically all of the construction which has occurred in such areas during the seven-year period.

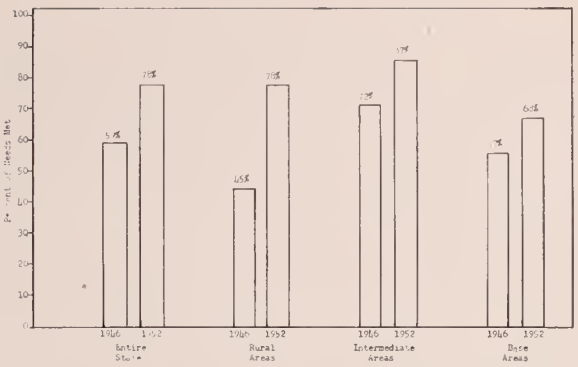



**Chart 1—Per cent of needs for general hospital beds met, years 1946 and 1952, state of Wisconsin (prepared by State Board of Health Division of Hospital and Related Services, February 1954).**

It is believed by the majority of the people who have benefited from the Federal aid that such facilities would not have been possible without the grants-in-aid program. Others have stated that their new facilities would not have been adequate in size or properly equipped without this financial aid.

TABLE 3—*Summary of Federal Hill-Burton Hospital Projects—Total Beds, Cost, Federal Share, and Distribution of Funds, Seven Fiscal Years, 1947–1948 to 1953–1954*

*State of Wisconsin**

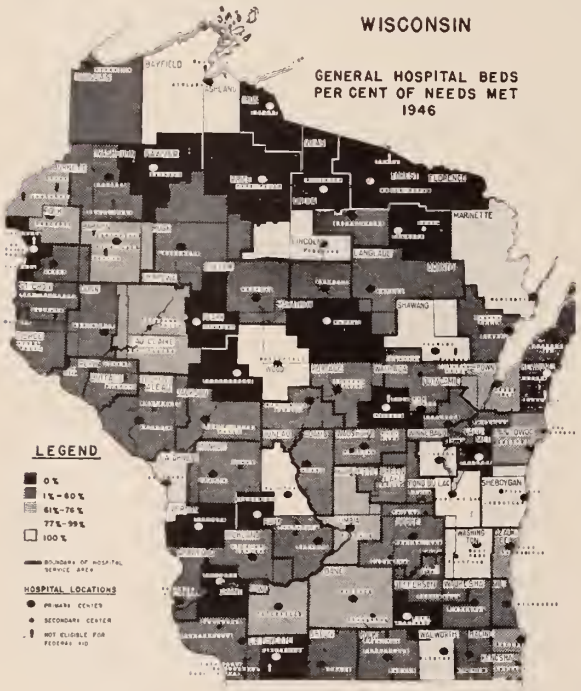
| CATEGORY | Number of Projects | Bed Capacities | | ESTIMATED TOTAL COST | | | Per Cent of Federal Share by Category |
|---|---|---|---|---|---|---|---|
| | | Normal | Maximum | Total | Sponsor's Share | Federal Share | |
| General Hospital Beds[1] | 38 | 1,334 | 1,626 | $23,946,000.00 | $14,535,000.00 | $ 9,411,000.00 | 75% |
| Other Categories: | | | | | | | |
| Chronic Disease Units | 4 | 221 | 254 | $ 4,135,000.00 | $ 3,054,000.00 | $ 1,081,000.00 | 9% |
| Psychiatric Units | 4 | 73 | 73 | 1,914,000.00 | 1,520,000.00 | 394,000.00 | 3% |
| Psychiatric Hospital | 1 | 248 | 248 | 2,823,000.00 | 1,910,000.00 | 913,000.00 | 7% |
| Laboratory of Hygiene | 1 | xxxxx | xxxxx | 1,693,000.00 | 931,000.00 | 762,000.00 | 6% |
| Sub-Totals | 10 | 542 | 575 | $10,565,000.00 | $ 7,415,000.00 | $ 3,150,000.00 | 25% |
| Totals | 48 | 1,876 | 2,201 | $34,511,000.00 | $21,950,000.00 | $12,561,000.00 | 100% |
| [1]Rural Areas Only= | 36 | 1,131 | 1,364 | $19,609,000.00 | $11,565,000.00 | $ 8,044,000.00 | 64% |

*Prepared by State Board of Health Division of Hospital and Related Services, January 1954.

### State Bed Needs Are Spotty

Chart 1 compares the per cent of needs met for the year 1946 with the per cent met for 1952 for the state as a whole and for the three classifications of areas. Again, it should be noted that the rural areas have made the greatest increase—from 45 per cent in 1946 to 78 per cent in 1952.

Having 78 per cent of the total beds needed, rural Wisconsin has reached the average for the state and is somewhat better supplied than the base medical centers, at least for the present.

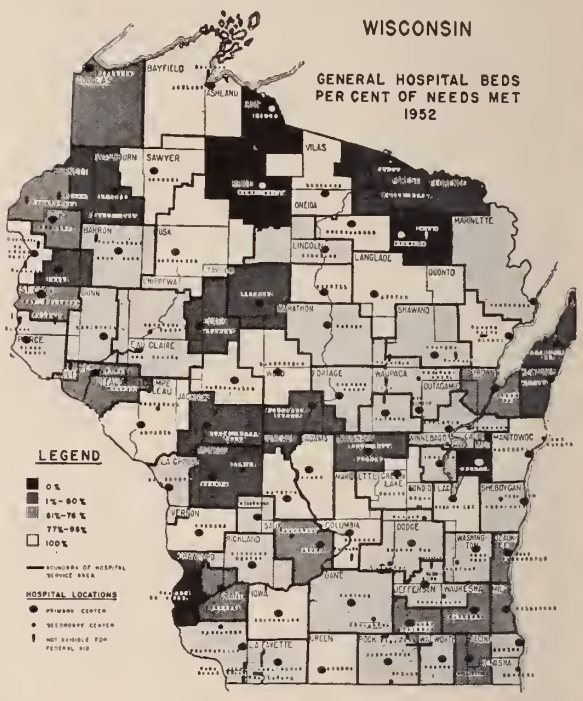



### State Bed Needs Reduced

Perhaps the most striking way to contrast the need for general hospital beds in 1946 with that in 1952 is through the two maps of the state shown here which present the per cent of needs met then and now.

It should be observed how many of the black and dark gray areas on the 1946 map became considerably brighter on the 1952 map.

It should also be noticed that while a few black and dark gray areas remain, even these areas, for the most part, are no longer *critically* in need of beds because in several




of the adjoining areas beds are now available beyond the immediate urgent needs of the hospital centers there. To illustrate, the centers at Chilton, Hurley, Spooner, and Crandon can use nearby facilities and have done so; but they may need hospitals from the long-range plan view-point. Park Falls is too distant from the nearest hospitals and will need a replacement of the present facility in the near future.

The irony of the developing situation is that unless certain urban areas begin to expand their hospital plants, they may find themselves in the position maintained by the rural areas for many years, that of having a shortage of urgently needed beds. As a matter of fact, Milwaukee and Green Bay are two such instances of areas where expansions are to start during 1954 to relieve a serious shortage of beds. For the reasons cited, a state hospital plan must be reviewed constantly to reflect the changing conditions. This is being done in Wisconsin, as in most states, by annual surveys of hospital bed capacities and utilization and a study of the economic factors influencing the demand for beds.

# Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

## REPORT OF A CASE*

*History:* This 52-year-old white woman was admitted to the University Hospitals on May 27, 1953. She had had a cholecystectomy 18 years prior to admission, and following this she had had intermittent episodes of jaundice and vomiting with interim asymptomatic periods. Five years prior to admission she underwent a second operative procedure to the common bile duct. The patient was then relatively asymptomatic until about a month prior to admission, when she developed severe left upper quadrant and left lower chest pain. She saw her local doctor at that time, and his examination revealed a marked anemia. She was hospitalized and soon thereafter developed gradually increasing jaundice, with persistence of pain in the left upper quadrant and lower left chest. The jaundice lasted about 10 days and then receded, to recur again about 4 days prior to admission accompanied by fever. (A flat plate of the abdomen before admission showed no free air). In the few days prior to admission the patient had had frequent episodes of vomiting and marked anorexia and had been receiving daily intravenous fluids. Past history revealed that she had had a hysterectomy for fibroid uterus 15 years ago and the gall bladder surgery as indicated above. At age 23 she had had pneumonia and was severely ill but apparently recovered without sequelae. A system review revealed that the patient had been dyspneic only with her recent illness and had noted occasional pedal edema. She had been constipated before the onset of her present illness, and since then the constipation disappeared. She had needed catheterization for urinary retention once in the 3 weeks preceding admission, although she had noted no dysuria or hematuria and only rare nocturia while at home. She had had pus in her urine while in the hospital. Her weight had been stable.

*Physical examination:* The admission physical examination revealed an acutely and chronically ill middle-aged white female who was in moderate respiratory distress and jaundiced. The blood pressure was 110/50; the pulse rate was 100; respirations were 24. The temperature was 103 F. There was dried blood in the right nostril. The upper jaw was edentulous. The tongue was coated and slightly dry. There were dilated veins over the anterior chest wall and breasts, and rales were heard over both lung bases posteriorly. The left border of cardiac dullness was 10 cm. to the left of the midsternal line in the fifth interspace, and there was a blowing systolic Grade II murmur heard over the entire precordium. The liver was grossly enlarged to about 8 cm. below the costal margin, had a rounded edge, and was non-tender. There was 1+ pretibial edema.

*Laboratory examination:* The admission urinalysis revealed a specific gravity of 1.011, slight albuminuria, and many white blood cells in the centrifuged sediment. The hemoglobin level was 6.25 Gm.; the red blood cell count was 2,280,000; the white blood cell count was 12,600; the differential contained 71 per cent filamented neutrophils, 19 per cent nonfilamented neutrophils, 7 per cent lymphocytes and eosinophils. The hematocrit reading was 27 per cent. The nonprotein nitrogen was 48 mg. per cent. The Coombs' test was positive on two occasions, and the reticulocyte count was normal. Stools were negative for ova, cysts, and parasites; and later in the patient's hospital course blood cultures were positive for Bacillus Alcaligenes repeatedly. A bedside chest x-ray on admission revealed an elevation of the diaphragm due to abdominal distention, the right dome being a little higher than the left. The right sulcus was obscured by a small amount of fluid in the pleural cavity; and there was a coarse linear streaking throughout the basal lung fields, probably due to pulmonary congestion. The heart was at the upper limits of normal in size. In the left base there were several shadows, nodular in character; and the question of metastasis was raised. A flat plate of the abdomen on admission revealed an indistinctly enlarged

* From the University Hospitals and University of Wisconsin Medical School.

liver but no other significant findings. A progress chest x-ray on May 31, 1953, revealed pulmonary congestion increased in amount over that noted before. There was persistence of the pleural effusion on the right and probably some on the left. A second progress film on June 11, 1953, revealed essentially no change. On May 30, 1953, serum electrolytes revealed the following: chlorides, 105 mEq.; sodium, 143 mEq.; potassium, 5.8 mEq. The carbon dioxide was 18 mEq. Liver function studies revealed total serum bilirubin of 5.1 mg. per cent, with 3.1 mg. direct van den Bergh. Prothrombin time was 77 per cent; the alkaline phosphatase, 16 units; cholesterol level, 100 mg. per cent; and the total serum proteins, 5.1 Gm. per cent, with 2.8 albumin and 2.3 globulin. The Hanger's test was 4+. An electrocardiogram on June 4, 1953, was considered as probably within normal limits with the exception of prolonged QT intervals for a rate of 80–85, which suggested electrolyte imbalance.

*Course:* Shortly after admission the patient was seen in consultation by the Surgery Department, and it was felt that she was too ill to consider surgery at that time. She was started on heavy doses of penicillin and streptomycin, before which a single culture was drawn which revealed no growth. In addition, she was given intravenous fluid, including considerable quantities of 10 per cent glucose. Mercuhydrin was used intermittently for what was considered pulmonary edema. The patient received a total of three 500 cc. blood transfusions during her hospital stay. She ran a febrile course throughout, with temperature spikes to a high of 103 F., until approximately the sixth day of her hospitalization, when the temperature reached 106 F. At the time her temperature reached 106 F. the serum bilirubin had dropped to a total of 2.88 mg. per cent, with 1.5 mg. per cent direct. At this time blood cultures were drawn and returned positive for Bacillus Alcaligenes, and sensitivity studies indicated that Aureomycin was the drug of choice. The patient was given both oral and intravenous Aureomycin but in spite of the above efforts became progressively worse; and on June 13, 1953, she was comatose and more dyspneic. At that time there were increasing signs of congestion in the right chest, and a friction rub was heard over the right anterior chest. There was also a marked centrifugal venous pulse in the left jugular vein. On June 13, 1953, the serum sodium fell to 118 mEq.; the carbon dioxide was 16.5 mEq. An attempt at correction of the sodium and carbon dioxide deficit was made, and on June 16, 1953, serum sodium was 128; potassium, 3.6; and carbon dioxide 25.5 mEq. The nonprotein nitrogen on that day had risen to 98 mg. per cent; and on June 18, 1953, it was 152, with a creatinine of 4.7. The patient did not regain consciousness after June 13, 1953. On June 15 anisocoria was noted, and there was marked hyperpnea. On June 16 neurological examination revealed the extremities to be flaccid, and there was absence of the left patellar reflex although it was present on the right. The right pupil was larger than the left. Rales increased in the chest; the pleural friction rubs were heard bilaterally. The patient expired on June 19, 1953.

### Clinical Discussion

**Dr. John Rankin:** The protocol describes a 52-year-old white female who was admitted to University Hospitals on May 27 of last year. A cholecystectomy was performed 18 years prior to admission. It would have been useful to have known for what purpose—for example, stones or infection or both—and perhaps we might have the answer from the history.

**Dr. D. M. Angevine:** I should say, Doctor Rankin, that at the time of operation five years prior to admission no stones were found.

**Doctor Rankin:** Thank you. At any rate, this first operation was followed by intermittent attacks of nausea, vomiting, and jaundice, suggesting intermittent obstruction and infection of the common bile duct, for which a second operation was performed about 10 years later. When the common bile duct was explored at this time, no stones were found. Another operation was performed 2 years later, at which time the common bile duct was drained and adhesions freed. At any rate, whatever the cause, initially stones must be considered as the most probable cause. She seems to have suffered from intermittent biliary obstruction, which was later relieved by a third operation. A month prior to admission, however, she developed left upper quadrant pain and lower chest pain. It is not certain whether this pain was pleuritic, colicky or continuous.

However, the main finding at this time was anemia. The pain in the chest persisted, and she gradually developed increasing jaundice which lasted for about 10 days, receded, and then recurred 4 days before admission accompanied by fever. At this time she apparently was suffering from frequent episodes of anorexia and vomiting, requiring parenteral fluids. An x-ray showed no free air in the abdomen. Slight dyspnea and ankle edema which were present had only been noted with the recent illness. Constipation, which had been a symptom, disappeared with the onset of the attack. Except for the necessity of catheterization on one occasion, there were no urinary symptoms. Her weight had been stable.

How can we account for these symptoms? I think we can assume that there were recurrent attacks of biliary obstruction and infection, the cause of which is not certain—either adhesions, chronic pancreatitis, or stone. I think we could probably rule out neoplasm at this time because of the long duration, the absence of weight loss, and the intermittency of the attacks. However, there are a few symptoms that are difficult to explain. Why was there pain in the left upper quadrant and the lower chest? Why was the patient dyspneic? Why was there pus in the urine? And why did she have ankle edema? The presence of edema may be explained on the basis of biliary cirrhosis, but then how do we account for the other symptoms? Perhaps she had had a recent attack of acute pancreatitis. Perhaps there was thrombosis of the hepatic or portal vein. Lastly, she may have had extensive suppurative changes and septicemia. We will deal with these after we have considered the physical findings.

These revealed an acutely and chronically ill middle-aged woman with respiratory distress, jaundice, and pyrexia with spikes up to 103 F. She had a grossly enlarged, nontender liver and dilated veins on the chest wall. All of these are in keeping with a diagnosis of intermittent biliary obstruction with a bacterial suppurative cholangitis and perhaps pylephlebitis. Jaundice, with or without colicky pains, and irregular spiking fever are the outstanding symptoms of this syndrome. However, on these occasions the liver is usually tender. This is also true for liver abscess. The free fluid in the abdomen suggests several possibilities, among which is pylephlebitis. We must consider one or two other syndromes at this point, however. The first is thrombosis of the hepatic veins, the so-called Chiari syndrome. This is suggested by the presence of the collateral venous channels and the moderate edema of the legs in addition to the jaundice and the rapidly enlarging liver. In this syndrome splenomegaly is not usually present, and hematemesis is not a characteristic feature. In thrombosis of the portal vein, on the other hand, splenomegaly is usually one of the main features; the liver is generally of normal size or atrophic, and hematemesis is a major feature of the illness. By the absence of splenomegaly and some of these other features we can pretty well rule out portal venous thrombosis. I may also mention that the collaterals, when there is thrombosis of the portal vein, are likely to be around the esophagus and also occur as hemorrhoids. It would have been nice to know what the direction of flow was in these veins. If the direction of flow was downward, it would suggest possible involvement of the inferior vena cava. The presence of some slight cardiac enlargement, a systolic murmur over the precordium, and rales in both lung fields suggests some cardiac involvement with pulmonary congestion. However, the Grade II systolic murmur in the presence of anemia and the fact that many of the other symptoms could be accounted for by other lesions make it difficult to be certain whether the patient did or did not have cardiac involvement. Other explanations would include infection beneath the diaphragm. Our greatest difficulty is to explain the association of the pain in the left upper quadrant and lower chest, which was followed by jaundice. Certain possibilities, including splenic infarction or abscess, arise here. In the absence of splenomegaly, however, it is difficult to accept these as more than possibilities; and certainly thrombosis of the splenic vein is a possibility, and the subsequent events are in keeping with this diagnosis. The absence of splenomegaly, however, is so difficult to explain in this syndrome that we must look for another cause. Although the main theme seems evident, we are still not very sure of some of the variations. Perhaps the laboratory studies may help.

The urinalysis showed a specific gravity of 1.011 and some albumin and pus in the urine. So we have evidence of a rather more widespread infection than simply in the biliary system. The absence of the usual symptoms of infection with pyelonephritis

in this patient suggests that the renal lesion may be a renal cortical abscess rather than pyelonephritis. The presence of nonprotein nitrogen of 48 indicates some evidence of renal failure or disturbance of electrolyte equilibrium. The white blood cell count of 12,600, with a polymorphonuclear leukocytosis is in keeping with our impression of infection. The patient did have evidence of a fairly severe anemia. The hemoglobin level was 6.25 Gm.; the red blood cell count, 2.28 mill.; the hematocrit reading 27 per cent. However, it is difficult to draw any conclusions from these findings. The mean corpuscular volume is 11; and if we work out the mean corpuscular hemoglobin concentration, it is 23. Obviously something must be wrong with one of these figures, and I suspect the blood count is too low. At any rate, we cannot say anything about the nature of the anemia from these findings. The reticulocyte count would seem to rule out hemolytic anemia and perhaps recent blood loss. The positive Coombs' test is a little confusing, and it is difficult to say anything very definite about it. I wonder whether it was done after she received her blood transfusion. Occasionally it is found in association with chronic liver disease and need not necessarily be an important factor here. Although this was certainly not the sole cause of her jaundice, there is no doubt that a hemolytic factor could have contributed to it and in some way been connected with the anemia. The blood cultures were positive for Alcaligenes faecalis. Now this is a motile organism found in normal stools. It is a normal constituent of the stool. Occasionally, however, it has been isolated from the urinary tract from cases of gastroenteritis, bacteremia, or meningitis in infancy. Personally, I have never heard of this organism producing widespread infection in an adult. However, these blood cultures appear to be repeatedly positive. Under favorable conditions these bowel saprophytes are able to initiate infection; for example, in infancy, in the presence of surgical infections of the bowel, perforation, peritonitis, and cholecystitis, particularly when obstruction is present. Perhaps the more frequent use of penicillin, destroying gram-positive organisms and allowing gram-negative penicillin-resistant organisms to flourish, produced a biological imbalance, which may predispose to infection. Certainly the most common site for these organisms is usually the urinary tract in the presence of obstruction. Almost all of the gram-negative enterococci form powerful endotoxins. Thus, it is possible to explain all of the symptoms in this case; indeed, they are all compatible with widespread infection with a gram-negative bacillus accompanied by septicemia. Without doubt, we have evidence of significant infection in the liver and bile ducts and probably the kidney. Some of the lesions suggest septic infarcts so that the possibility of a bacterial endocarditis must be entertained. These organisms not infrequently produce an ulcerative endocarditis, and this could explain some of the puzzling features of this case.

Let us, however, examine some of the other laboratory findings. The electrolytes were done on May 30; the chlorides at this time were 105 mEq.; sodium, 143 mEq.; potassium, 5.8 mEq. and the bicarbonate, 18 mEq. There is nothing very striking about these figures. The liver function tests showed bilirubin of 5.1 mg. per cent total; prompt, direct van den Bergh, 3.1 mg. The prothrombin time was 77 per cent; the alkaline phosphatase, 16 units; cholesterol level, 100 mg. per cent; protein, 5.1 Gm. per cent, with albumin 2.8; and a Hanger's test, 4+. These are indications of a mixed hepatocellular and obstructive jaundice such as is occasionally found in longstanding obstructive jaundice. Probably there is only partial obstruction. Since there is no mention of abnormal color of the stools or pruritus from retention of bile salts, we can only confirm the fact that there is severe liver damage and that in addition there is an obstructive element.

What about the prolonged QT intervals seen in the electrocardiogram? This finding is by no means specific as it is occasionally found in cardiac enlargement from any cause; however, it is found most frequently in hypokalemia, hypocalcemia, rheumatic carditis, myxedema, and diffuse myocardial disease from any cause. The absence of any mention of T wave changes would seem to rule out hypokalemia; and, in fact, the rather definite absence of any other abnormality would suggest that perhaps there was a lowered calcium in the blood. Unfortunately, we do not have the calcium figure.

The patient's course in the hospital was as follows: Shortly after admission she was seen in consultation with the surgeons, who thought that she was too ill to consider surgery. Penicillin and streptomycin were

administered, and this combination of antibiotics is certainly one of the most useful in the presence of mixed infections with organisms from the bowel. In addition, considerable quantities of 10 per cent glucose solution were administered intravenously. Presumably saline was not used at this time because of what was presumed to be pulmonary edema. For the same reason Mercuhydrin was administered, and subsequent events raise doubts as to the wisdom of this therapy. However, it is easy to be wise after the event; and at this stage I doubt that any therapy would have altered the outcome. In spite of a decrease in the total and the prompt reacting bilirubin to 2.88 and 1.5 mg. respectively, the patient's physical status continued to deteriorate; and the spiking temperature continued. On one occasion, the sixth day after admission, it rose to 106 F., and at this time her blood cultures were again positive for Alcaligenes faecalis. Sensitivity tests suggested the drug of choice to be Aureomycin, which was given both intravenously and orally. Her condition continued to deteriorate until, on the eighteenth day, she was comatose and showed increasing signs of congestion in the chest, where there was also a pleural friction rub. Coma at this stage could have been explained in many ways—toxemia, shock, hepaticorenal failure. On that day the serum sodium was 118 mEq.; the bicarbonate radical, 16.5 mEq.; and nonprotein nitrogen, 98 mg. per cent. This certainly represents a severe degree of electrolyte depletion, particularly of sodium, and probably renal failure. At this level of sodium it is not possible to say whether the bicarbonate of 16.5 milliequivalents per liter represents acidosis without further supportive evidence. Personally, I find it more useful to have the chloride and bicarbonate determinations done at the same time rather than the sodium level and bicarbonate determination, although one certainly feels happier in these cases when the investigations also include sodium, potassium, calcium, and phosphorus. At any rate, replacement therapy was given. We are not told exactly how much but by the twenty-first day the sodium was 128; potassium, 3.6; and bicarbonate, 25.5 mEq., which certainly shows some improvement. In spite of this, however, the nonprotein nitrogen had risen to 152, with a creatinine of 4.7. The two questions we would like to have asked at this time are: "Was the blood pressure reasonably normal?" and "What was the urinary output?" We have evidence that the patient had a very marked renal failure. The high nonprotein nitrogen perhaps rules out, although not completely, another possibility in this patient—that of acute hepatic necrosis.

On the eighteenth day another interesting observation was made; namely, that marked centrifugal venous pulse was seen in the left jugular vein. Why not also in the right jugular vein? I don't know, perhaps it was in both. This, at any rate, indicates either heart failure of the right ventricle with dilatation and incompetence of the tricuspid ring or an ulcerative endocarditis of the tricuspid valve. If the pulsation was definitely systolic, then I would feel rather certain of the latter; however, it is difficult to tell with a fast pulse rate.

On the twentieth day after admission the pupils were unequal, and there was marked hyperpnea. Apparently this was not Cheyne-Stokes respiration, and it is difficult to say with certainty what the cause of the hyperpnea was. The extremities were flaccid, and the left patellar reflex was absent; also, the right pupil was larger than the left. In addition to the coma, for which we have a variety of potential causes, there was obviously some local lesion in or around the temporal lobe near the posterior part of the internal capsule. However, we cannot state with any degree of certainty what the nature of that lesion was. It may have been caused by a state of shock with low blood pressure; it may have been embolism, infected or otherwise; it may have been a terminal hemorrhage or a small abscess. On the other hand, patients with terminal hepatic failure may show signs of focal lesions in the brain when at autospy it is difficult to see any lesion grossly. It is certain that we now have some pulmonary infection.

There are certainly a number of obscure factors in this patient, and there are a number of things one would like to have known. For example, was there ever any evidence of bleeding into the alimentary canal? Was the spleen palpable at any time? Did the liver ever decrease in size throughout the course of the illness? What was the direction of flow in the collaterals in the chest? And what was the nature of the anemia? What was the cause of it? Also, what was the patient's urinary output and blood pressure in the last few days? However, in spite of not

knowing these things, I can summarize by saying that this is a middle-aged woman with chronic recurrent infection and obstruction of the biliary tract, with considerable liver damage—biliary cirrhosis if you like—possibly stone, and possibly a pancreatic lesion. She had had a more recent attack of suppurative cholangitis with possible pylephlebitis and further liver damage and also a spread of the infection to the subphrenic region and possibly to the pancreas. There is suggestive evidence of hepatic venous thrombosis, with possible involvement of the inferior vena cava. Septicemia occurred with a normally saprophytic bowel organism, and probably there were embolic septic infarcts in the lung, kidney, and brain. There is a suggestion of an ulcerative endocarditis of the tricuspid valve and possibly cardiac failure. There is terminal hepatorenal failure, severe anemia and toxemia with cerebral insufficiency, and possibly some local lesion in the brain. In spite of all that, it is impossible to exclude the presence of a neoplasm. However, if it is present, the terminal event was undoubtedly infection.

**Doctor Angevine:** As you might expect from Doctor Rankin's discussion, this case is interesting from the standpoint of the pathologist, so I've asked Doctor Hahn to discuss the autopsy findings.

**Dr. Kurt Hahn:** The autopsy revealed three groups of findings which are apparently related. First, there was a complete obstruction of the common bile duct by multiple stones, and there was an adjacent large lobulated abscess in the gallbladder region. Second, there was a septic thrombus in the hepatic part of the vena cava. And third, there were multiple septic processes in the heart, in the lungs, in the liver, kidneys, and brain. On dissection of the common bile duct, multiple stones were encountered, extending up into the biliary tract of the liver. The largest stone measured 2.5 cm. It was possible to express 10 to 12 smaller stones. In the region of the gallbladder a large abscess was found; it measured about 7.5 cm. across and contained 80 cc. of a foul-smelling dark green material. The lateral abdominal wall was also involved in this abscess, and several pockets of pus were noted. The vena cava adjacent to the infected areas contained an ante mortem thrombus which was 3.5 cm. in length and firmly attached to the wall. Later we were able to demonstrate large colonies of bacteria. So, without doubt, this thrombus was the cause of the widespread generalized infection. The heart revealed a fresh vegetative endocarditis on the cusps of the aortic valve. The other valves were not involved. There was a minimal pericarditis. The myocardium was brownish red in color and very friable. All appendages were empty. The vegetations were quite adherent. Cultures were taken from the valves.

The next lesions were encountered in the lungs. The right lung showed a moderate amount of emphysema and atelectasis that one might expect in a person of this age. However, the most important finding was a large abscess on the diaphragmatic surface of the lower lobe. This abscess was 8 cm. in diameter and surrounded by a wide area of atelectasis. There was a marked pleural reaction, and we encountered 500 cc. of a cloudy bad smelling fluid in the right pleural cavity; this is in keeping with the physical findings. Furthermore, it was possible to demonstrate widespread fibrinous adhesions. The abscess contained a large amount of a thick greenish pus.

The liver had a weight of 2,500 Gm., or 100 Gm. more than normal. On the right posterior diaphragmatic surface, a large abscess was encountered. This abscess measured 14 x 5 x 5 cm. and contained thick yellowish-green pus. Cultures from this location also were taken. The right kidney had a weight of 270 Gm. The capsule was easy to remove; however, the entire organ was considerably swollen. The surface revealed a mottling with many cysts and small yellowish abcesses. On cut section there was poor distinction between cortex and medulla. There was a streaking of the infectious processes from the cortex into the medulla; the amount of pelvic fat was considerably increased. This indicates a severe infection of the kidney. On gross examination the brain was completely normal; however, on microscopy it was possible to demonstrate inflammatory lesions in the parietal cortex and the medulla, especially close to the olive.

As already indicated, several cultures were taken; however, it was not possible to demonstrate one predominant organism. The report indicates only that it was possible to demonstrate the presence of Bacterium pyocyaneus, aerogenes and Streptococcus faecalis. I should add here that the weight of the spleen was 450 Gm. and that the spleen on cut section was extremely soft, indicating

an acute splenic tumor. Furthermore, the bone marrow revealed a depression of the erythropoietic elements.

Summarizing, we consider that this person's death was due to a septicemia caused by obstruction and chronic infection of bile ducts.

**Doctor Angevine:** I have no way of proving it, but I believe that this patient's difficulty began with her operation 18 years ago. Sometimes when the gallbladder is removed, the cystic duct is tied off a little closer than it should be and one gets stasis of bile so that there is a site for the formation of stones. As Doctor Rankin has intimated, this person had had, from time to time, a low-grade infection of the biliary tree in the form of a cholangitis; and when this organism, the Alcaligenes faecalis, which is usually considered a nonpathogen, is recovered from the blood stream, most people pay little attention to it. In this case it did considerable damage and was recovered on several occasions. This is not the first case we have seen where this organism produced a bacteremia and a pyemia.

**Dr. P. F. Clark:** I would just like to say that any organism may be pathogenic if conditions are such that it has an opportunity to grow.

# ANNUAL MEETING HIGHLIGHTS

## Milwaukee, October 4–5–6

## *Scientific Demonstrations*

**Monday, October 4: 9:00–10:00 a.m. and 3:00–3:45 p.m.**

**Tuesday, October 5: Same schedule as Monday**

**Wednesday, October 6: 9:00–10:00 a.m.**

1. **POSTANESTHESIA RECOVERY ROOM:** Presented by the Wisconsin Society of Anesthesiologists, with demonstrations under the immediate direction of James Bookhamer, M.D., Milwaukee

2. **SPECIAL MEDICAL PROBLEMS OF THE AMPUTEE:** Demonstrations under the direction of Ray Piaskoski, M.D., VA Center, Wood. The coordinated demonstration will feature comments of a physiatrist, an orthopedist, a physical therapist, a limb fitter, and a vocational counselor. Patients of Wood will be used for the demonstrations.

3. **SPECIAL PROBLEMS OF DELIVERY:** Members of the Wisconsin Society of Obstetrics and Gynecology will present special manikin demonstrations on the following subjects:
   **Monday a.m.:** "Version Extraction and External Version"
   **Monday p.m.:** "Management of Transverse Presentation and Breech Presentation"
   **Tuesday:** Same schedule as Monday but with different demonstrators
   **Wednesday a.m.:** "Manual and Forceps Rotation of the Occiput Transverse and Occiput Posterior Presentations and Positions"
   (Use will also be made of the teaching film developed at Northwestern University on "Manual Rotation in the Management of Occiput Posterior and Occiput Transverse Positions")

4. **FRACTURES AND INTRAMEDULLARY NAILING OF THE FEMUR:** Members of the Wisconsin Orthopedic Society will conduct the demonstrations, under the immediate direction of Joseph Stone, M.D., Milwaukee

5. **ANATOMY DISSECTIONS:** To be provided by Frederick Geist, M.D., and associates, University of Wisconsin Medical School. The cranial cavity will be discussed, with emphasis upon information directed to the general practitioner. In one specimen the cranial meninges, cerebral veins, fluid spaces, meningeal vessels, and dural sinuses will be featured. A second specimen will present the dorsal view of the brain stem and a complete laminectomy. Both demonstrations will also be supplemented by a dissection of the arteries of the base of the brain.

6. **GROSS TISSUE:** The Wisconsin Society of Pathologists will present tissues of special significance throughout the three-day session.

**For Other Highlight Features, See Page 333 of This Issue**

# Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

## Questions and Answers Suggested by Recent Investigations in Drug Therapy

*In what skin condition does Terramycin (oxytetracycline) appear especially effective?* In a study at Temple University, Carroll S. Wright and Donald N. Tschan[1] used Terramycin ointment in the treatment of 845 patients, 635 of whose cases were followed to completion of therapy. Only 4 had irritation leading to discontinuance of medication; patch tests on all 4 revealed sensitivity to the petrolatum base. All reactions to patch tests with Terramycin were negative.

The most striking results were obtained in cases of impetigo contagiosa. Of 90 patients with this malady, 82 were cured in one to seven days, and the other 8 in fourteen days or more. Deeper infections responded more slowly, but 101 of 106 patients were cured. The ointment cleared up secondary impetiginization in 110 of 133 patients with contact and atopic dermatitis, dermatophytosis, and seborrheic eczema.

Three of 17 patients with acne vulgaris were much improved, but in the other 14 effects were negligible. Viral diseases of the skin and dermatoses other than infections—such diseases as psoriasis, herpes zoster, herpes simplex, verruca vulgaris, seborrheic eczema, molluscum contagiosum, and erysipeloid—failed to respond.

Terramycin ointment was used to dress wounds after removal of various types of skin growths. In all but 2 of 244 cases the wounds healed without complication. In the two exceptions, use of the ointment was discontinued because of sensitivity to the petrolatum base.

*In this antibiotic era, what two major problems remain to be solved in lung resection for tuberculosis?* From the Veterans Administration Hospital at Oteen, North Carolina, James D. Murphy and Barney B. Becker[2] report results in 49 lobectomy and 51 pneumonectomy patients with pulmonary tuberculosis who had not received streptomycin until one week before and two weeks after operation. Follow-up time on the pneumonectomy group ranged from 36 to 59 months and on the lobectomy group, from 36 to 72 months. In the pneumonectomy group there were three early operative deaths due, respectively, to cerebral anoxia, hemorrhage, and tuberculous pericarditis and two late deaths due to tuberculous meningitis and to diabetic coma. In the lobectomy group there were four early operative deaths due to pulmonary edema, pulmonary embolism, cardiac arrest, and postoperative hemorrhage.

In the pneumonectomy group early complications occurred in 15 cases: bronchopleural fistula in 9, empyema in 2, tuberculous pericarditis in 2, and pneumonitis and spread of the disease in 1 each. Late complications included reactivation of the disease in 3 cases, extrapulmonary tuberculosis in 2, tuberculous endobronchial disease in 1, and tuberculous wound abscess in 3. In the lobectomy group there were early complications in 6 cases: spread of disease in 2 and bronchopleural fistula, empyema, postoperative psychoses, and pneumonitis in one each. Late complications included reactivation in 12 cases; endobronchial disease in 1; and extrapulmonary tuberculosis, tuberculous wound abscess, and hemoptysis in 2 each.

Examinations of sputum for tubercle bacilli revealed that in the pneumonectomy group 68.6 per cent had completely negative, 19.6 per cent infrequently positive, and 88.2 per cent currently negative sputum. In the lobectomy group 55.1 per cent had completely negative, 26.5 per cent infrequently positive, and 81.6 per cent currently negative sputum. In the pneumonectomy group 82.3 per cent of the patients have been discharged from the hospital and in the lobectomy group, 77.5 per cent.

This study shows that pulmonary resection can be done with a reasonable morbidity and mortality. Postoperative bronchopleural fistula and late reactivation of disease are the major problems which remain to be

solved. Despite the total mortality rate of 9 per cent, 85 per cent of the patients had sputum negative for Mycobacterium tuberculosis at the end of three years.

*Why may it be that pain will be relieved only in duodenal, not gastric, ulcer by anticholinergic drugs?* Since physiologists hold that pain fibers in the gastrointestinal tract are insensitive to chemical stimuli, and the introduction of acid into the stomach of ulcer patients nevertheless causes pain though it arouses no sensation in normal individuals, it must surely be conceded that pain in peptic ulcer results from stimulation by acid of afferent nerves in the ulcer base—unless the stimulation of these nerves by acid initiates motor activity reflexly and the motor activity causes the pain. A recent report of Walter L. Palmer and associates[3] at the University of Chicago denies the latter possibility and postulates that the only circumstance in which anticholinergic drugs may be expected to relieve pain is that in which the rate of gastric emptying is decreased. Thus there can be hope of effecting relief with anticholinergic agents only in duodenal but never in gastric ulcer. This is certainly a challenging and provocative viewpoint.

*What should probably be the maximum maintenance dosage of cortisone after the menopause?* From a recent study of their own and the observations of others, H. F. West and G. R. Newns[4] concluded that for women in the childbearing years with rheumatoid arthritis, cortisone acetate, 50 to 75 mg. daily for periods up to 21 months, does not upset normal function. In women after the menopause, 75 mg. of cortisone acetate a day should be the maximal maintenance therapy.—HARRY BECKMAN, M. D.

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3. Palmer, Walter L., Vanstcenhuyse, Firman, and Kirsner, Joseph B.: Peptic ulcer: effect of anticholinergic drugs on mechanism of pain, Am. J. M. Sc. 224:603–611 (Dec.) 1952.
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## ANESTHESIA AND ANALGESIA

Physicians attending births can provide valuable information by carefully recording anesthetics and analgesics that were used under Item 29 on the latest birth and fetal-death certificates. This data is being collected and tabulated at the request of the State Medical Society's Division on Maternal and Child Welfare, which is currently undertaking special studies on maternal and fetal-neonatal deaths.

One of the problems encountered has been the reporting of such non-specific items as "General," "Gas," "Routine," "Ob," or just a "√" or "X." Even worse is no entry at all—which could mean the type of anesthetic and analgesic was not indicated or that none was used.

Information gleaned from birth certificates in the past has been valuable to all practicing physicians in Wisconsin. It has broadened knowledge of problems and helped to direct effort toward improved care which has reduced maternal and infant deaths. To be of real value, information collected must be meaningful. We therefore urge all physicians attendant at deliveries to help by entering the *specific* anesthetic and analgesic or "None" if none was used.—ROBERT PURTELL, M. D., *Chairman, Division on Maternal and Child Welfare.*

## ANNUAL MEETING ROUND TABLES

The complete schedule of round tables has been arranged for the Annual Meeting; and your notice, with the reservation slip, should reach your office on or close to July 15.

Be sure that you make your reservations as quickly as possible after receipt of the brochure because there is limited attendance at each of the round tables.

# THE WISCONSIN MEDICAL JOURNAL

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# « « « EDITORIAL » » »

## Tuberculosis Geriatric Problem

The mobile x-ray units operated by the State Board of Health are turning up interesting statistics as far as tuberculosis is concerned. Findings are highest in the older age groups and, consequently, our thinking about tuberculosis is going to have to be changed. Most of us think of TB as a disease of young adults; but evidently our nation-wide campaigns to curb this disease have been very effective in reducing the incidence in the younger age groups, yet not so effective for the oldsters. All studies throughout the country are showing similar conclusions.

Since cancer of the lung is becoming much more common and it, too, occurs in the older age group, or at least predominantly in those over 45, the State Medical Society's Division on Tuberculosis and Chest Diseases of the Commission on State Departments is studying a suggestion that case finding in tuberculosis and lung cancer be correlated and that a definite program be instituted to get the mobile x-ray units to concentrate more on the adult members of the population rather than solely on schools.

The statistical department of the Wisconsin Anti-Tuberculosis Association has made a study which confirms the fact that there is a high incidence of cancer of the lung among the older age group and that the incidence in those persons in nursing homes and institutions is highest of all. Therefore, it would seem that nursing homes; workers in industry; and, in general, the adult population could well be surveyed intensely in search of both tuberculosis and cancer.

Incidentally, have you had your chest x-rayed lately, Doctor?

## A New "High" in Annual Meetings

The Council on Scientific Work has completed the 1954 Annual Meeting program, and details will be announced to members during the summer months. A list of speakers will be found on page 333 of this issue.

The general chairman, Doctor Peter Midelfart, Eau Claire, has secured outstanding teachers from all parts of the country and Canada as program participants. These outstanding leaders in medicine are coming to our meeting in Milwaukee without financial reimbursement other than a sum provided to meet expenses. Their greatest reward will be attendance of Wisconsin physicians and active participation of our members in the various discussions provided.

# . . . . THE PRESIDENT'S PAGE . . . .

WHEN a physician looks back some 35 years and compares how he was taught with how he now teaches medical students, he can not resist hoping that he will live another 35 years and be sufficiently *compos mentis* to make such comparisons again. The far-reaching implications of these changes should not be deferred another 35 years, but should be met on a "plan-as-you-go" basis. And on that basis, these are some of the thoughts that come to mind.

There is a very real and present danger that we will forget that the physiology of man and the psychology of man is now "as it was in the beginning and evermore shall be." In other words, man himself has not changed in complexity. It is simply man's knowledge of man's complexity that is increasing at a truly staggering rate. Thus, if man is deprived of certain "protective" foods and vitamins, he will respond as of yore and develop rickets or scurvy or what not, even though the biochemical roentgenographic changes going on within him are pretty well understood. Also, if man—especially in his formative years—is exposed to certain environmental psychic traumatizing experiences, he is quite sure to show the same type of psychic aberration that was familiar to his ancestors, even though modern psychiatrists may call it by a new and hard-to-understand name. Parenthetically, let us say here that man is endowed with a God-given resilience which allows him to resist most environmental mal-influences and go on to a perfectly normal development. This is indeed a fortunate fact—otherwise we would all be a little more "nuts" than we are.

SO WHAT? Well, so simply this: Man is a warm-blooded gregarious animal and when something goes wrong, either within or without, he must have a warm-blooded, gregarious animal—in the role of an understanding physician—help him out of his trouble or, if need be, help him to learn to live with his trouble. It is not enough that the physician knows to the fraction of a milliequivalent what is wrong in the man's biochemical reactions; and this is the clear and present danger—that eager young medical men, responding to the pressure of their teachers, may forget that how a man *feels* towards himself and towards his environment will have a profound influence on his actions and may indeed alter his biochemical reactions. Thus, there is the ever-present necessity of regarding the patient as a whole individual, not as a series of holes to be investigated.

And continuing this line of thought, it is logical to consider another matter. But in this I see no "clear and present danger" to the patient.

The increasing complexity of diagnostic and therapeutic technics continues to require more and more specially trained people, both to perform and to interpret these technics. Thus, the logic of a necessity for "group" or so-called "clinic" practice; and in all our discussions of this subject we must never lose sight of the basic purpose of this type of practice, the welfare of the patient. The concentration of such services as x-ray, laboratory, physiatry, and the clinic pharmacy falls within this category, the welfare of the patient. Yes, even the much criticized "clinic pharmacy" makes its contribution to the welfare of the patient.

Beginning only a short while ago, organized medicine has been asked to practically "outlaw" the establishment of clinic pharmacies on the grounds that they violate that section of our code of ethics which says that a physician shall receive remuneration only for his professional services and not for drugs or appliances. This seems like a clear enough statement, but we must never forget that the basic purpose of a code of ethics is to protect the patient from possible exploitation. Thus, the division of a single fee between two physicians who participate in the care of a patient will do that patient no harm. But the practice of "fee splitting," as that term is generally understood, may very well lead to those evil twins, "ghost surgery" and "unnecessary surgery." Therefore, any manipulation of fees which might lead to these practices must be discouraged, and discouraged in no uncertain terms. But it is difficult to see how the clinic pharmacies can do the patient any harm. They are under the direction of registered pharmacists, and hence there can be no question as to the quality of the service they render. They free the pharmacist from com-

petition with ten-cent stores and liquor stores and thus allow him to devote full time to his chosen profession. Actually, the clinic pharmacist is an integral part of the group and is so regarded by the rest of the group. Thus, the professions of pharmacy and medicine can work in even closer harmony to achieve their common goal, the welfare of the patient.

However, there is one problem related to the clinic pharmacy which should be mentioned for the sake of condemning it. That is the use of "code prescriptions." In some clinics "abbreviated" prescriptions are used as a matter of convenience, but the full formula is freely available to any pharmacist on request. But if a prescription is written so that it is intelligible only to the clinic pharmacist, then it violates not a code of ethics, but the basic concept of "free choice." I firmly believe that the principle of "free choice" should apply to the pharmacist, just as we have long insisted that it applies to the clergyman and the physician. So if this principle is adhered to, I believe there is little chance of anyone being hurt by the clinic pharmacy.

H Kent Tenney M.D.

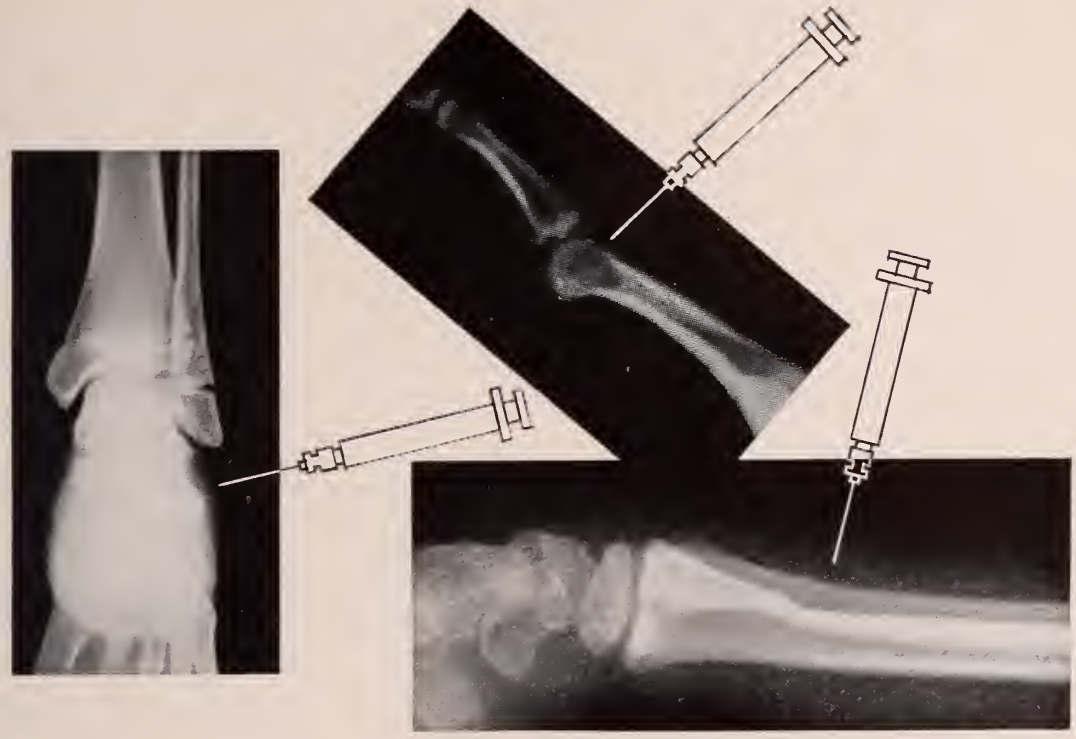
## BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the last half of 1954 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referral be made by the family physician; but when this is not feasible, arrangements may be made by writing to the Bureau. Forms for the purpose of referral may be obtained from the Bureau of Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify for which clinic forms are wanted.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of the fact.

| | |
|---|---|
| Eau Claire | July 29, 30 |
| Ashland | August 11, 12 |
| Wausau | August 25, 26 |
| Manitowoc | September 1, 2 |
| Marinette | September 8 |
| Kenosha | September 15, 16 |
| Green Bay | September 23, 24 |
| Superior | September 29, 30 |
| La Crosse | October 12, 13, 14, 15 |
| Racine | October 20, 21 |
| Sheboygan | October 28, 29 |
| Rhinelander | November 3, 4 |
| Eau Claire | November 11, 12 |
| Appleton | November 18, 19 |
| Fond du Lac | December 1, 2 |
| Chippewa Falls | December 9, 10 |

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.



# Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

*In traumatic surgery[1] where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means[1, 2] of accelerating dispersion of accumulated fluids.*

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The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anesthesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

Fluids administered with Alidase are rapidly absorbed from subcutaneous tissue. The simplicity of hypodermoclysis avoids the cumbersome arm board, permits convenient administration with little or no pain or swelling, is vein-sparing and saves nursing time in such conditions as burns, postoperative states, toxemias and parenteral alimentation.

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1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, J. Bone & Joint Surg. *35-A*:604 (July) 1953.
2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, Am. J. Surg. *87*:384 (March) 1954.

# Society Proceedings

## Brown—Kewaunee—Door

On May 13 the members of the Brown—Kewaunee-Door County Medical Society, together with the dentists of the area, held a Cancer Diagnostic Teaching Clinic. This clinic was arranged by the Cancer Committee of the State Medical Society. Cases were selected by *Drs. J. L. Ford* and *S. M. Mokrohisky* and were presented by the physicians in charge and then discussed by the guest speakers. The meeting was held at the Elks Club, Green Bay.

## Calumet

At a dinner meeting of the Calumet County Medical Society held at the Hotel Chilton in Chilton on April 24, *Dr. F. P. Larme*, New Holstein, and *Dr. John Guthrie*, Brillion, were re-elected president and secretary–treasurer, respectively. *Dr. Everett W. Humke*, Chilton, was elected delegate to the State Medical Society House of Delegates.

Guest speaker for the evening was *Dr. Phillip M. Kauth*, West Bend, who presented a travelogue and showed colored movies of his trip around the world.

## Chippewa

Thirty-five members of the Chippewa County Medical Society held their April meeting at the Hotel Northern, Chippewa Falls, on April 13. Dr. Norbert Hanson of the Mayo Clinic, Rochester, Minnesota, discussed "Rauwolfia Serpentina."

The dinner was in honor of *Dr. Stephen E. Williams* of Chippewa Falls, commemorating his 50th year in the medical profession. The society also recognized that Dr. W. A. Smith of Boyd, Wisconsin, had also achieved his 50th year in the medical profession. Doctor Smith was unable to attend this meeting because of hospitalization due to a recent injury.

**Pictured above are Dr. S. E. Williams, his four sons, and Dr. C. B. Hatleberg, Chippewa Falls. From left to right are Colin Williams, Chippewa Falls; Dr. Lowell Williams, Waukesha (dentist); Dr. C. B. Hatleberg; Dr. S. E. Williams; Dr. Bruce Williams, Duluth; and Stephen Williams, Duluth.**

## Dodge

A dinner meeting for the members of the Dodge County Medical Society was held on March 25 at the Elks Club, Beaver Dam. *Dr. Abraham Melamed* of Milwaukee showed films of routine admission chest x-rays. *Dr. H. G. Bayley*, radiologist from Beaver Dam, discussed the admission chest x-ray examination program at Lutheran Hospital, Beaver Dam, where 97 per cent of all admitted patients are included in the program.

On April 29 the members gathered at the Waupun Memorial Hospital to view a color-sound movie concerning gastrointestinal carcinoma, provided by the Wisconsin Division of the American Cancer Society.

At the Elks Club on May 27, *Dr. W. S. Middleton*, Madison, spoke to the society on the subject "Recent Trends in Medical Therapy." A buffet lunch followed the meeting.

## Douglas

Members of the Douglas County Medical Society met at the Hotel Superior, Superior, on May 5 to hear *Dr. Edwin F. Schneiders*, Madison. He spoke on "Cancer of the Uterine Cervix and Fundus."

## Fond du Lac

The April meeting of the Fond du Lac County Medical Society was held on Tuesday, April 22, at Cap's Steak House in Peebles. After dinner the members heard *Dr. Sture M. Johnson*, Madison, speak on "Photosensitivity Dermatosis and Differential Diagnosis of Eruptions of the Hands and Feet."

## Green Lake—Waushara

Eleven members of the Green Lake—Waushara County Medical Society met at the Hotel Whiting, Berlin, on April 22 to hear *Dr. J. E. Gonce*, Madison. Doctor Gonce spoke on "Respiratory Obstruction in Infants and Children."

A committee was appointed to meet with the welfare directors of Green Lake and Waushara counties for the purpose of discussing possible changes in the welfare department medical fee schedule.

## Kenosha

The Elks Club, Kenosha, was the meeting place for 42 members of the Kenosha County Medical Society on May 6. The members heard Dr. Kenneth Johnston of the Department of Laryngology, University of Illinois, Chicago, give a review of foreign bodies in the air and food passages.

## Marinette–Florence

April 21 was the date for the members of the Marinette–Florence County Medical Society to gather at the Riverside Country Club, Menominee, Michigan, for a dinner meeting. They heard *Dr. L. J. Van Hecke*, Milwaukee pathologist, speak.

## Polk

Dr. William Fleeson, child psychiatrist from the Minnesota Psychiatric Institute, spoke to the members of the Polk County Medical Society on March 12. He spoke on the subject "Guidance Service for Children." At the business session the assistance in the county immunization program by the medical society and a preventive mental health program were discussed..

Sixteen members of the society went to the home of Dr. Joe Belshe, Taylor Falls, Minnesota, on April 15 for a dinner meeting and a talk by Dr. Robert Knutson, anesthesiologist of St. Luke's Hospital, St. Paul, Minnesota. Doctor Knutson spoke on "Newer Trends in Anesthesia." *Dr. Rex Graber*, district health officer from Chippewa Falls, discussed the gamma globulin distribution. The society decided not to request mass immunization for the coming season.

## Sheboygan

"Estate Planning for the Physician" was discussed by Mr. Joseph Schilder, vice-president of the Security National Bank, Sheboygan, at the April 22 meeting of the Sheboygan County Medical Society held at the Riverdale Country Club, Sheboygan. An active question and answer period followed the presentation.

At the business portion of the meeting, *Dr. E. T. Hougen* was appointed to serve as the society representative on the Community Welfare Council. *Dr. I. L. Schroeder* was appointed to serve on the Welfare Panel of the Council. *Dr. W. W. Moir* discussed the planning necessary to set up a program using radioactive isotopes in one of the Sheboygan hospitals.

## Trempealeau–Jackson–Buffalo

On April 27 the members of the Trempealeau-Jackson–Buffalo County Medical Society and their wives met at the hotel in Mondovi to hear Dr. Robert W. Utendorfer present the topic for the evening. Doctor Utendorfer is a surgeon located at the Veterans Administration Hospital in Minneapolis.

## Walworth

A general discussion by the members present followed a talk on "Parental Fixations in Children" given by *Dr. Joseph E. Vaccaro*, Milwaukee, at the April 8 meeting of the Walworth County Medical


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Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, August 9, October 11
Surgical Anatomy & Clinical Surgery, Two Weeks, June 21, August 23
Surgery of Colon & Rectum, One Week, September 13
Basic Principles in General Surgery, Two Weeks, September 20
Breast & Thyroid Surgery, One Week, June 21
Thoracic Surgery, One Week, October 11
Esophageal Surgery, One Week, October 4
General Surgery, Two Weeks, July 26; One Week, October 4
Gallbladder Surgery, Ten Hours, October 25
Fractures & Traumatic Surgery, Two Weeks, October 25
GYNECOLOGY—Office & Operative Gynecology, Two Weeks, September 20
Vaginal Approach to Pelvic Surgery, One Week, June 21
MEDICINE—Two-Week Course, September 27
Electrocardiology & Heart Disease, Two Weeks, July 12
Gastroenterology, Two Weeks, October 25
RADIOLOGY—Diagnostic Course, Two Weeks, October 4
Clinical Course, Two Weeks, by appointment
Radiation Therapy, by appointment
PEDIATRICS—Clinical Course, Two Weeks, by appointment
Congenital & Rheumatic Heart Disease in Infants & Children, One Week, October 11 and October 18; Two Weeks, October 11
UROLOGY—Two-Week Urology Course, September 20
Ten-Day Practical Course in Cystoscopy every two weeks

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Society. The meeting was held at the Colonial Hotel, Delavan, and was attended by 17 members.

A report was made by *Dr. R. A. Moses*, Delavan, on the progress of the study club which is sponsored by the county society. Diamox, a new oral diuretic, its pharmacology, toxicity, and uses had been discussed at a recent meeting of the study club. *Dr. John E. Martin*, Delavan, presented a paper on "Treatment in Toxemias of Pregnancy" at the April meeting of the study club.

### Waukesha

*Dr. Raymond P. Welbourne*, Watertown, presented a paper on the "Carcinoma of the Lower Bowel" at a meeting of the Waukesha County Medical Society held on April 7. The meeting was held at Preston's Restaurant, Hartland.

### Wisconsin Urological Society

The 28th annual meeting of the Wisconsin Urological Society was held at the Retlaw Hotel in Fond du Lac on Saturday, April 24, with society president, *Dr. Edward B. Jacobson* of Milwaukee, presiding.

The program for the day was presented by five members and two guest speakers. It included an address by Dr. John R. Robinson of Kankakee, Illinois, on "Water Balance" and two presentations by Dr. John K. Lattimer from Columbia University, New York City, one on "Genitourinary Tuberculosis," the other on "Radical Retropubic Prostatectomy for Carcinoma."

Officers elected for the next year were:

President—*Dr. H. K. Guth*, Fond du Lac
Vice-president—*Dr. James J. King*, Milwaukee
Secretary-Treasurer — *Dr. E. F. Cummings*, Oshkosh.

# News Items and Personals

### Doctor Cinelis Resumes Practice in Sheboygan

*Dr. Ann Cinelis*, after being away from the city of Sheboygan for a period of 10 months, has announced that she will again have an office there. During the 10-month period, she has practiced at Black River Falls and Independence.

Prior to studying for a career in medicine, Doctor Cinelis trained to be a nurse and practiced her profession. She was graduated in 1936 from St. Agnes School of Nursing, Fond du Lac. She received her Doctor of Medicine degree from the University of Wisconsin in 1948 and served her internship at Marshfield.

### Doctor Hovda Joins Tomah VA Staff

*Dr. A. A. Hovda* has joined the medical staff at the VA Hospital, Tomah. He will be working in the psychiatric division. Doctor Hovda was discharged from the U. S. Navy early this year after a year spent in the Far East. He has practiced in Tomah since the middle of February; and prior to entering the service, he had practiced there for two years. He is a graduate of Ohio State University College of Medicine.

### Dr. Frederick Bauer Retires

After serving the community of Shawano for 15 years, during 14 of which he was city health officer, *Dr. Frederick Bauer* has retired from the active practice of medicine.

Doctor Bauer attended the University of Illinois, graduating in 1906. In addition to being city health officer, he was institutional physician at the county hospital and home for five years and had held many offices on the Shawano Municipal Hospital staff and in the county medical society. Before coming to Shawano, Doctor Bauer had practiced in Milwaukee for 20 years and also in Illinois.

### Doctors Prentice Open Office in Mellen

*Dr. J. W. Prentice* and his son, *Dr. Culver Prentice*, both of Ashland, have announced that they will open offices in Mellen for two afternoons a week in the near future. Dr. J. W. Prentice has practiced in Ashland since 1929 and at present is president of the Wisconsin State Board of Medical Examiners. Dr. Culver Prentice received his medical degree from the University of Minnesota. Then following a two-year internship at St. Mary's Hospital, Minneapolis, he practiced in association with his father.

### Dr. A. C. Theiler to Have Office at Kiel

*Dr. A. C. Theiler*, who is planning to move to Kiel from Princeton about August 1, will have office hours in Kiel two days a week, it was announced on April 30. His offices will be in the Kiel Clinic.

Doctor Theiler is a native of Tomahawk and was graduated from Marquette University School of Medicine. He interned at St. Luke's Hospital, Milwaukee, and then spent two years in army medicine in Korea and a year at Wood Veterans Hospital. He has been practicing at Princeton since 1949.

### Dr. and Mrs. Gnagi Join in European Tour

*Dr.* and Mrs. *W. B. Gnagi*, Monroe, were among 500 members of the American College of Surgeons

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who were guests of English and French surgeons during a European tour. The group left New York by plane on May 8.

The first stop was at Glasgow, where the Irish-Scottish group joined the tour. On May 11 the surgeons drove to Edinburgh, where an honorary degree was conferred on Dr. E. A. Graham, American lung cancer expert, by the Royal Academy of Surgeons. Other meetings of English and American surgeons were scheduled at Leeds and London, and the group planned an auto trip to Harrogate. On May 24 the group crossed the channel to Paris, where French surgeons were hosts to the American surgeons. Lyon, Marseilles, and Nice were other cities in the itinerary. The trip ended May 31.

Doctor and Mrs. Gnagi continued the tour by visiting Italy, Switzerland, and Spain.

## Symposium for Medical Group Held at Wausau

A symposium on fluid and electrolyte metabolism sponsored by the Marathon County Medical Society was held at the Wausau Club on May 12.

Faculty members from the University of Minnesota Medical School took part in the symposium and answered questions in the evening. These physicians were Dr. Ellis S. Benson, laboratory service; Dr. Edmund B. Flink, department of medicine; and Dr. Bernard Zimmermann, department of surgery. Doctors Flink and Benson discussed the general principles of "Fluid and Electrolyte Metabolism in Health." The three physicians then discussed some abnormalities in fluid and electrolyte balance. Illustrative cases pertained to dehydration, overdehydration, low sodium syndrome, potassium deficiency, hyperpotassemia, and acidosis or alkalosis.

The afternoon program closed with a discussion of management of fluid and electrolyte balance in surgical and non-surgical patients.

## Testimonial Dinner Given for Doctor Hildebrand

A testimonial dinner in honor of *Dr. W. B. Hildebrand*, Menasha, who recently assumed the presidency of the American Academy of General Practice, was held May 11 at the Menasha Elks Club.

The dinner was arranged by *Drs. J. P. Canavan* of Neenah and *George Pratt* of Menasha. Guests were present from Madison, Milwaukee, and various parts of the state. *Dr. George Forkin*, Menasha, was toastmaster; brief remarks were made by state president, *Dr. C. G. Reznichek*, Madison, and former president, *Dr. E. C. Cary*, Reedsville. *Dr. E. L Bernhart* and *Dr. Robert F. Purtell*, both of Milwaukee, also spoke briefly.

## Dr. Gerald Rau Elected to Fellowship

Dr. Herman H. Kahlenberg, formerly of Two Rivers and presently director of Kahlenberg Laboratories, Sarasota, Florida, has announced that *Dr.*

*Gerald A. Rau*, Manitowoc, had been elected a Fellow of the American Association for the Advancement of Science.

Nominations for the position must be made by three Fellows before the new candidate is accepted. In addition to Doctor Kahlenberg, those who submitted Doctor Rau's name were *Dr. Erwin R. Schmidt*, professor of surgery and chief surgeon, University of Wisconsin, and *Dr. Walter J. Meek*, former professor of physiology, acting dean of the medical school, and now professor emeritus, University of Wisconsin.

Among Doctor Rau's publications are papers on improved methods of treating epidermophytosis and the uses of bichloracetic acid in dermatology. His latest researches are in the field of gynecology and deal with new and better methods of treating cervical erosions. Doctor Rau has written a paper on this subject and it has been accepted for publication.

## Doctor Doege Leaves Marshfield Clinic

*Dr. Paul F. Doege*, Marshfield physician and surgeon, ended 24 years' association with the Marshfield Clinic on May 1. He will continue a private practice at St. Joseph's Hospital, Marshfield.

His father, the late Dr. Karl W. Doege, was one of the clinic founders in 1916. A 1926 graduate of Harvard Medical School, Doctor Doege is one of the founders of the Wisconsin Surgical Society and recently spoke to the group at a meeting at the Veterans Administration Hospital in Madison on the subject of "Carcinoma of the Cervix and Chronic Cervicitis."

## Doctor Moody Is Guest Speaker

When the 46th annual meeting of the Wisconsin Anti-Tuberculosis Association was held at the Hotel Pfister, Milwaukee, on April 8 and 9, *Dr. L. W. Moody*, superintendent and medical director of Pure Air Sanatorium, Bayfield, discussed the role of the sanatorium in tuberculosis case-finding.

Governor Walter J. Kohler spoke on "Outstanding Health Needs in Wisconsin." The theme of the meeting was "Progress Brings Problems." About 500 persons from Wisconsin and neighboring states attended.

## Doctor Van Hecke to Serve as Pathologist for Waupun Hospital

*Dr. L. J. Van Hecke*, Milwaukee, assistant professor of pathology at Marquette University, spoke to the medical staff of the Waupun Memorial Hospital on April 8. Doctor Van Hecke discussed the post-surgical tissue procedure which is now required of all accredited Class A hospitals. A new program, under which all tissues removed during an operation will be sent to Doctor Van Hecke for pathological examination, is being instituted at the Waupun hospital. Doctor Van Hecke will meet with the hospital staff at periodic intervals to discuss the findings.

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## Doctor Pelkey Opens New Office

*Dr. Ralph Pelkey* of Pound has opened a new office. It has 11 rooms—five examining rooms, an x-ray room, reception room, waiting room, drug room, and two private offices. About 1,000 persons attended the reception and opening of the new offices.

## Dr. Robert M. Senty Joins Sheboygan Clinic

A specialist in internal medicine and diagnosis, *Dr. Robert M. Senty* has become a member of the staff of the Sheboygan Clinic. Doctor Senty received his pre-medical course at the University of Wisconsin and was graduated from the medical school there in 1947. After leaving the University, he went to the Charles T. Miller Hospital in St. Paul, Minnesota. He served his internship there from July, 1947 to July, 1948, and then served an additional period of time from July, 1948 to September, 1950 as a resident in internal medicine.

Following his residency, Doctor Senty was at Camp McCoy from September, 1950 to September, 1951, where he was chief of the medical service. From September, 1951 to March, 1952, he served at the Walter Reed Hospital in Washington, D. C., where he was enrolled in the Army Medical Graduate School. He went overseas in April, 1952 and was located in Frankfurt, Germany; here he was the commanding officer of the 10th General Dispensary, one of the largest outpatient dispensaries in the American Occupation Zone in Germany. He was separated from active duty in the U. S. Army on January 9, 1954.

Doctor Senty is presently on the staffs of St. Nicholas Hospital and Sheboygan Memorial Hospital.

## St. Joseph's Hospital, Chippewa Falls, Has Staff Elections

The staff of St. Joseph's Hospital, Chippewa Falls, met on April 19 and elected the following officers:

Chief-of-Staff—*Dr. C. B. Hatleberg*, Chippewa Falls

Assistant Chiefs-of-Staff—*Dr. William C. Henske*, Chippewa Falls; *Dr. D. F. Hudek*, Bloomer

Secretary—*Dr. Paul W. Murphy*, Bloomer.

# THIRD AND TWELFTH DISTRICTS NEWS

## Dane

March 9 was the date of the regular monthly meeting of the Dane County Medical Society. The meeting was held at the Madison Club, Madison, and was devoted entirely to a business session. *Dr. A. L. Tatum*, Madison, was voted an honorary membership in the society; *Dr. G. G. Stebbins*, Madison, reported on a geriatric study being conducted in

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J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
James F. McDonald, Jr., M. D.
Wendell T. Wingett, M. D.

Dane County by the doctors, hospitals, and nursing homes. The remainder of the meeting consisted of a report by *Dr. J. S. Supernaw*, chairman of the War Bond Committee, on capital investments of the society.

Thirty members of the society met on April 13 at the Madison Club to hear *Dr. James M. Wilkie*, Madison, speak on "Farmers Lung." He illustrated his talk with films taken on his cases.

Mr. Ralph Metz, executive secretary of the United Givers and Community Welfare Council, spoke to the members on May 11, explaining the organization of the Welfare Council. The scientific portion of the meeting was presented by *Dr. A. L. Rhoades*, ophthalmologist from Madison. He presented colored slides of external eye conditions.

## Dr. Arnold Jackson Honored in South America

*Dr. Arnold S. Jackson*, Madison, left on a three-week tour of South America on April 20. While there, he received an honorary degree, lectured, and attended medical meetings. He returned to Madison on May 10.

Doctor Jackson received an honorary degree from the Surgical Society of Lima, Peru, and in Lima was a guest of Dr. Francisco Grana, with whom he traveled abroad in 1951. At São Paulo, Brazil, he attended the world meeting of the International College of Surgeons, which was being held there in connection with the 400th anniversary of the State of San Paulo. At this meeting, he gave an illustrated lecture on tumors of the neck.

He also visited Rio de Janeiro and San Juan on his return trip in connection with his activities with the College. Doctor Jackson will be installed as president of the American Chapter of the International College of Surgeons in Chicago next September.

## Welfare Board Honors Doctor Lorenz

The State Board of Public Welfare voted on April 14 to honor *Dr. William F. Lorenz*, director of the Wisconsin Psychiatric Institute at Madison, by naming a new reception and intensive treatment building at Mendota State Hospital after him.

This, the board said, "will honor Doctor Lorenz for his long and distinguished service to mental hygiene in Wisconsin."

## Dean Middleton Attends Paris Meetings

*Dr. William S. Middleton*, dean of the University of Wisconsin Medical School, flew to Paris, France, on May 7 to attend meetings of the North Atlantic Treaty Organization (NATO). He participated in the meetings at the request of the Department of Defense. Doctor Middleton returned to Madison on May 14.

## Doctor Albright Attends Medical Meetings

*Dr. Edwin C. Albright*, Madison, left on April 27 to attend the American Goiter Association meeting in Boston. He went on from there to Atlantic City to attend the American Society for Clinical Research meeting.

## Doctor Loveland Opens Office in Madison

A 1953 graduate of the University of Wisconsin, *Dr. Pearl M. Loveland* has opened an office in the Tenney Building, Madison, for the general practice of obstetrics. Doctor Loveland interned at Madison General Hospital and has been a Madison resident since 1946.

## Doctor Puestow Elected Regent

*Dr. Karver L. Puestow*, a specialist in internal medicine and Fellow of the American College of Physicians, was elected one of six regents of the College at a meeting in Chicago on April 8. Doctor Puestow is a clinical professor of medicine at the University of Wisconsin.

## Doctor McCormick Speaks on Psychiatry

*Dr. Stuart A. McCormick*, Madison, spoke to the Medical Moments interest group of the University of Wisconsin Dames at its meeting in the Memorial Union, Madison, on April 28. He spoke about psychiatry.

## Dr. John Allen Opens Office

*Dr. John Allen*, Madison, has announced that he has resigned as medical director of Oscar Mayer and Company, a post he has held for two years. He has opened an office for the private practice of medicine, pediatrics, and obstetrics in Madison. He will continue to serve as in-plant instructor in industrial medicine for the University of Wisconsin Medical School and also will be medical consultant to Oscar Mayer and Company.

## Madison Has New Internist

*Dr. Evlyn M. Anderson*, who is on the staff of the Veterans Administration Hospital in Madison, has opened an office for the private practice of internal medicine in Madison. She is a 1949 graduate of the University of Iowa College of Medicine. She interned in San Francisco, California, and she has had three and one half years of special training at the University of Colorado, Milwaukee County Hospital, and State University of Iowa Hospital.

## Wisconsin Association for Public Health Honors Two Doctors

At the annual state meeting of the Wisconsin Association for Public Health held in Madison on May 3 and 4, citations were awarded to *Dr. Harry M. Guilford*, Madison, and *Dr. Valentine A. Gudex*, Milwaukee. Doctor Guilford's citation pointed out

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his dedication "to the service of his fellow man" and his contributions "to the health of a people and their happiness and knowledge." "Untiring efforts in the interest of the public's health which have unquestionably contributed much to the health and happiness of your fellow citizen," was on the citation presented to Doctor Gudex. Both men were awarded honorary life memberships in the association.

## Milwaukee

Two noted physicians talked to members of the Medical Society of Milwaukee County at the organization's annual cancer meeting on April 8. The two physicians were Dr. Owen H. Wangensteen, chief of the department of surgery at the University of Minnesota Medical School, Minneapolis, and Dr. L. Henry Garland, clinical professor of radiology at the Stanford University School of Medicine at San Francisco. Doctor Wangensteen discussed surgery for cancer of the alimentary tract, and Doctor Garland talked about treatment of breast cancer. The meeting was sponsored by the Milwaukee division of the American Cancer Society.

## Dr. Otto H. Foerster Honored

*Dr. Otto H. Foerster*, dermatologist in Milwaukee for many years, was elected an honorary member of the American Dermatological Association at its 74th annual meeting held in April at the Greenbrier, White Sulphur Springs, West Virginia. Doctor Foerster is a former president of the association and is professor emeritus of dermatology at the University of Wisconsin Medical School.

Having twice served as president of the Chicago Dermatological Society, in 1912 and 1927, Doctor Foerster was elected honorary president of the year by the society at its meeting in February.

## Doctor Shutkin Speaks to Medical Technologists

*Dr. Michael W. Shutkin* of Milwaukee spoke before the state convention of the Wisconsin Association of Medical Technologists on May 8. "The Clinical Significance of Laboratory Aids in Gastroenterology" was the subject of his talk.

## Doctor Sargent Presents Paper to American Association of Genitourinary Surgeons

*Dr. James C. Sargent*, Milwaukee, read a paper entitled, "Vesicovaginal Fistula: An Effective Technique of Repair," on the program of the American Association of Genitourinary Surgeons meeting at Shawnee on the Delaware from May 26 to 28. He also prepared a 600-foot, 16 mm., silent, color moving picture based upon this material and showed it


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at the annual meeting of the American Urological Association in New York City on May 31. He will also show the film at the American Medical Association meeting in Atlantic City in June 1955.

## Marquette University School of Medicine Dedicates New Library

A five-day program marked the formal opening and dedication, on May 18 to 22, of the new Eben J. and Helene M. Carey Memorial Library addition to the Marquette University School of Medicine. The new $1,100,000 addition is named in honor of the late Doctor Carey, who was dean of the school, and the late Mrs. Carey. They and Marquette medical alumni made the library possible with their contributions.

Highlighting the dedication week was a two-day conference on hemorrhagic diseases and formal blessing of the building on May 22. World-renowned specialists in the field participated in the conference on hemorrhagic diseases. Among those physicians were Dr. Tage Astrup of the Carlsberg Foundation, Copenhagen, Denmark; Dr. Alfredo Pavlovsky of the Naval Hospital, Buenos Aires, Argentina; and professors from Columbia, Harvard, John Hopkins University, Marquette, Michigan, Missouri, North Carolina, Syracuse University, Tufts College, Utah, Wisconsin, and Yale. A $5,000 grant from the Milwaukee Froedtert Foundation made the conference possible.

Chairmen of the conference sessions included *Dr. John S. Hirschboeck*, Marquette School of Medicine dean; *Dr. Roman E. Galasinski*, president of the Marquette Medical Alumni Association, which held its annual spring reunion and clinic on May 22; and *Drs. Harry Beckman* and *Francis D. Murphy* of the faculty. Moderators were *Dr. Armand J. Quick*, professor and director of the department of biochemistry at Marquette; Dr. Harry P. Smith, Columbia University; and Dr. Maxwell M. Wintrobe, University of Utah.

Lecture demonstrations on "Cardiac Arrest" and "Cardiac Catheterization" were also held on May 22. An informal dinner dance was held that night at the Wisconsin Club.

The five-day schedule was opened with a Milwaukee Academy of Medicine tour of the new building and a dinner program in Marquette's Brooks Memorial Union on the night of May 18. The toastmaster was *Dr. Arthur A. Holbrook*, president of the Academy; and principal speaker was Dr. Sidney Farber, director of the children's cancer research foundation and professor of pathology at Harvard Medical School. A civic dinner meeting at Brooks Union on the night of May 20 was addressed by Dr. Roscoe Miller, president of Northwestern University and former dean of medicine there. He discussed "The Community and the University."

A student awards convocation was held in the Marquette Medical Auditorium on the afternoon of May 19, and open house for the public was con-


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ducted from 2 to 5 p. m. and 7:30 to 9:30 p. m. on May 21. Several exhibits had been arranged by various Marquette medical departments for the open house.

## Wisconsin Trudeau Society Meets in Milwaukee

Two Madison doctors spoke at the spring meeting of the Wisconsin Trudeau Society held in Milwaukee in April. The two doctors, *Helen A. Dickie* and *Joseph W. Gale*, appeared in a symposium on recent advances in the treatment of pulmonary tuberculosis.

At an election meeting, *Dr. Raymond Evers*, superintendent and medical director of Rocky Knoll Sanatorium, Plymouth, was elected president; Doctor Dickie was named vice-president; and *Dr. John Mendenhall* of the VA Hospital, Madison, was named secretary-treasurer.

## Milwaukee Neuro-Psychiatric Society

As the guests of the Wisconsin Neurological Foundation, the Milwaukee Neuro-Psychiatric Society met in Madison on April 21. The program included an inspection of the Wisconsin Neurological Foundation Rehabilitation Center, Madison; and a scientific session consisted of a symposium on neuromuscular disease. The physicians participating in the symposium were *Dr. Hans H. Reese*, Madison, who spoke on "Present Day Problems in Muscular Disorders," and Dr. John Harman, Madison, who spoke on "Biochemical Concept of Muscular Function."

The society held its May 19 meeting at the University Club, Milwaukee, where Dr. Ralph D. Rabinovitch, associate professor of psychiatry at the University of Michigan, spoke on "The Psychiatric Evaluation of Current Trends in Child Care Practice."

## Milwaukee Oto-Ophthalmic Society

Members of the Milwaukee Oto-Ophthalmic Society met at the University Club on April 27. They heard Dr. T. S. Szewczyk of East St. Louis, Illinois, speak on "Retrolental Fibroplasia."

## Milwaukee Academy of Medicine and Milwaukee Society of Internal Medicine Have Joint Meeting

"Problems of Carcinoma of the Bronchus" was the subject presented to the members of the Milwaukee Academy of Medicine and the Milwaukee Society of Internal Medicine on April 27 when they held a joint meeting at the University Club. Dr. Juan Del Regato, director, Penrose Cancer Hospital, Colorado Springs, Colorado, presented the talk.

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## Doctor Musser Speaks in Milwaukee

*Dr. Marc J. Musser*, Madison, spoke on "The Attitude of the Aging Individual to Physical Illnesses" on April 15 in the Marquette University School of Medicine auditorium. The talk was sponsored by the Milwaukee County Society for Mental Health.

## MARRIAGES

*Dr. Ralph E. Teitgen*, Milwaukee, to Katherine A. Mensing, Milwaukee, March 27.

*Dr. D. H. Jeffers, Jr.*, Lake Geneva, to Catherine Mary MacLean, Delavan, March 27.

## SOCIETY RECORDS

### New Members

P. H. Marty, New Glarus.

T. J. Budnick, Waterford.

B. E. Clarke, 2900 West Oklahoma Avenue, Milwaukee.

J. E. Groh, 3037 South 62nd Street, Milwaukee.

Murray Herman, 3520 South 23rd Street, Milwaukee.

E. S. Levy, 606 West Wisconsin Avenue, Milwaukee.

T. F. Jennings, 7240 West Center Street, Milwaukee.

J. L. Raschbacher,** Kewaskum.

Helen V. Gruhl, 2731 East Beverly Road, Milwaukee.

J. F. Koppa, 4238 North 44th Street, Milwaukee.

N. J. Lockowitz, 2510 West Capitol Drive, Wood.

G. A. Dedinsky,** 5000 West Chambers Street, Milwaukee.

J. R. Kuzdas, 629 Menomonee Avenue, South Milwaukee.

K. A. Bittle,** 4103 West Fond du Lac Avenue, Milwaukee.

H. M. Roberts,** 8721 West North Avenue, Milwaukee.

R. E. Cullen, 1300 University Avenue, Madison.

H. C. Evans, Jackson.

H. C. Deering, Badger Ordnance Works, Baraboo.

J. A. Tasche,** 720 Erie Avenue, Sheboygan.

A. A. Teitgen,** 927 South Eighth Street, Manitowoc.

E. C. Jarvis,** Tomahawk.

George Kordiyak, 126 Grand Avenue, Wausau.

R. M. Senty, 1011 North Eighth Street, Sheboygan.

E. F. Pischke, 113 Third Street, Baraboo.

J. T. Gericke, 204 East Grand Avenue, Eau Claire.

V. R. Vanstane, Edgerton.

T. W. Dorman, 19 South Main Street, Janesville

J. E. Abrams,** 2319 North Second Street, Milwaukee.

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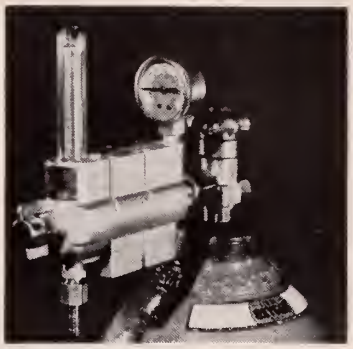

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J. A. Arkins, 4119 North Ardmore Avenue, Milwaukee.

T. P. Borowski, 918 East Howard Avenue, Milwaukee.

P. F. Nordin, 7922 West Center Street, Milwaukee.

C. T. Atkinson, 703 West Walnut Street, Milwaukee.

### Changes of Address

Charles P. Giesen, Sturgeon Bay, to 2103 North 62nd Street, Milwaukee.

O. C. Clark, Oconomowoc, to 326 Windsor Drive, Waukesha.

H. J. Kanin, Brooks Air Force Base, Texas, to 5515 West Melvina, Milwaukee.

H. E. Thimke, Shawano, to 402 Grandview Court, Iowa City, Iowa.

Dorothy H. W. Oakley, Clinton, Massachusetts, to 618 West Lakeside Street, Madison.

A. P. Klotz, La Grange, Illinois, to 8329 High Drive, Kansas City, Missouri.

Herbert Frank, Fargo, North Dakota, to 2616 South Twyckenham Drive, South Bend, Indiana.

A. E. McMahon, Jr., Stevens Point, to 15 Westview Drive, Mason City, Iowa.

R. R. Redlin, Coronado, California, to Crescent Drive, Elm Grove.

J. J. Klobucar,* Green Bay, to U. S. Army Hospital, Fort Riley, Kansas.

G. V. Hering,* Denmark, to 717 New River Drive, Jacksonville, North Carolina.

D. K. Buffmire, Appleton, to 550 West Thomas Road, Phoenix, Arizona.

N. S. Davis, Jr., Sister Bay, to Providence Hospital, Seattle, Washington.

N. L. Weber, Seattle, Washington, to 3821 South Howell Avenue, Milwaukee.

J. K. Trumbo, Augusta, Georgia, to Battle Creek Sanitarium, Battle Creek, Michigan.

J. J. Frederick,* San Antonio, Texas, to 3565th U. S. A. F. Hospital, Box 522, James Connally Air Force Base, Waco, Texas.

K. O. Ghormley, La Crosse, to 2 West Fern Avenue, Redlands, California.

J. R. Richter, Chaseburg, to 203 Fifth Avenue, South, La Crosse.

W. E. Braun, Kenosha, to 412 West Main Street, Merrill.

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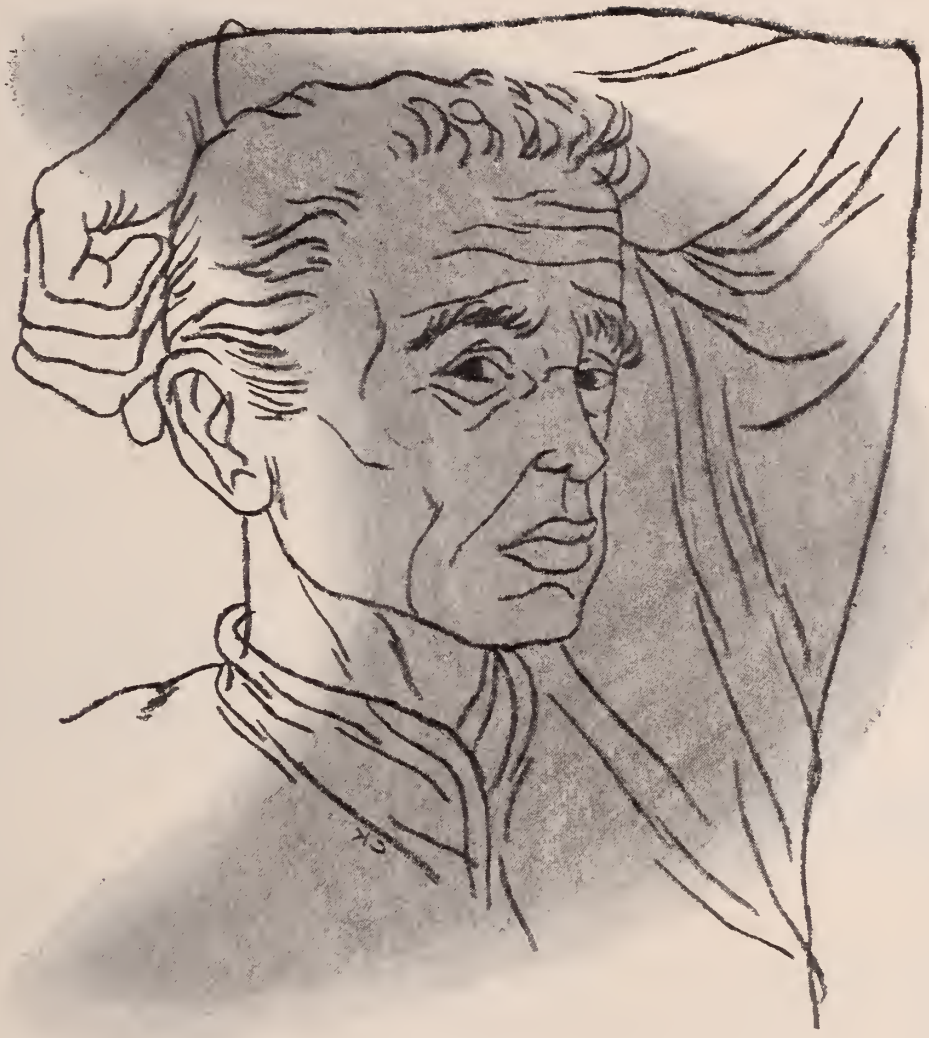

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1. Gurdjian, E. S., and Webster, J. E., Amer. J. of Surgery, 63:236, 1944.

## DEATHS

**Dr. R. E. Van Schaick** died on April 26 at the Clintonville Hospital, where he was a member of the staff. He was born on July 20, 1887, and was 66 at the time of his death.

A graduate of the Wisconsin College of Physicians and Surgeons, Milwaukee, in 1910, he interned at St. Joseph's Hospital, Milwaukee, in 1910 and at Milwaukee County Hospital, Wauwatosa, in 1912. In 1912 he went to Caroline and remained there until 1923, when he began his practice in Marion. In September of 1950 Doctor Van Schaick was involved in an automobile accident and has had a limited practice since that time.

Doctor Van Schaick was a member of the Waupaca County Medical Society, the State Medical Society, and the American Medical Association.

Surviving are his widow, Edyth, and two brothers, Shirley of Milwaukee and Dr. Harold of Miami, Florida. His three children preceded him in death.

**Dr. Joseph A. Mudroch**, 70, prominent Columbus physician for more than 40 years, died on April 17 after a long illness.

He was born at Tisch Mills, Manitowoc County, on Christmas Day in 1883 and was a member of the first class to graduate from the Manitowoc County Normal some 50 years ago. He attended Marquette University and was graduated from Northwestern University Medical School. He interned at Milwaukee Hospital from 1910 to 1911. In 1912 he moved to Columbus and practiced there until his death.

He was a member of the Columbia–Marquette-Adams County Medical Society, the State Medical Society, and the American Medical Association.

Survivors include his widow, Amanda; a daughter, Mrs. John Jaeger, Madison; a son, Dr. Robert Mudroch, Columbus; one brother, Rudolph, Milwaukee; and a sister, Mrs. James Hanus, Milwaukee.

**Dr. Jean A. Jackson**, 80, a retired physician from Mosinee, died on May 3 at a Wausau hospital. He had retired in 1950 after 33 years of practice at Mosinee. Doctor Jackson was a member of the Fifty-Year Club of the State Medical Society.

He was born on July 7, 1873, in the town of Vernon. After taking a four-year course at Carroll College, he studied electrical engineering at the University of Wisconsin for two years. He was called home for two years due to illness, and after that period he entered Bennett College, now a part of Loyola University, Chicago, and was graduated from that medical school in 1901. For two and one half years following his graduation, he practiced medicine at Berlin. From there he moved to Randolph, where he practiced for 14½ years. In 1917 he moved to Mosinee and practiced there until his retirement in 1950.

In 1947 Doctor Jackson and the late Dr. Edward F. Butler were honored at a testimonial dinner in honor of their active participation in medical, athletic, fraternal, and civic activities in Mosinee.

For eight years he was a member of the Mosinee school board. A past president of the Wood County Medical Society and the Marathon County Medical Society, he was also a life member of the State Medical Society and a member of the American Medical Association.

Doctor Jackson is survived by one son, Eben, of San Diego, California, and four daughters, Miss Janet Jackson, Menomonee Falls; Mrs. George Griggs, Lake Orion, Michigan; Mrs. Herbert Siekert, Wausau; and Mrs. James Gowing, San Diego, California. Doctor Jackson's wife, Clara, preceded him in death by three weeks.

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# RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Madison, January 12 through 14, 1954:

| *Name* | *School of Graduation* | *Year* | *Address* |
|---|---|---|---|
| Arnold, Thomas S. | Western Reserve University | 1948 | 826 North Eighth Street, Manitowoc. |
| Bartholomew, Richard D. | Marquette University | 1948 | 9540 Beverly Place, Wauwatosa. |
| Bigalow, James F. | University of Kansas | 1944 | Merrill. |
| Blackburn, Marvin D., Jr. | Baylor University | 1942 | Bellin Memorial Hospital, Green Bay. |
| Bonner, Joseph N. | Georgetown University | 1942 | 103 West College Avenue, Appleton. |
| Cleary, Joseph W. | Louisiana State University | 1949 | St. Joseph's Hospital, Milwaukee. |
| Erickson, Norman W. | Northwestern University | 1950 | 176 Oak Street, Juneau. |
| Ferm, V. H. | Western Reserve University | 1948 | 1246 Williamson Street, Madison. |
| Glassy, Frank J. | Marquette University | 1946 | 8700 West Wisconsin Avenue, Milwaukee. |
| Herman, Murray | New York Medical College | 1949 | 3523 South 23rd Street, Milwaukee. |
| Kendell, William G. | University of Michigan | 1946 | 92 East Division, Fond du Lac. |
| Lunseth, John H. | University of Illinois | 1945 | Milwaukee County General Hospital, Milwaukee. |
| Maire, Lewis E. | Wayne University | 1943 | 8220 Portage Road, Dexter, Michigan. |
| Mateo, Guillermo G. | University of Chicago | 1948 | 1036 South Eighth Street, Manitowoc. |
| McFetridge, James G. | University of Manitoba | 1937 | 411 West Dickens Avenue, Chicago, Illinois. |
| McMahon, Arthur E., Jr. | University of Iowa | 1948 | 15 Westview Drive, Mason City, Iowa. |
| Petsch, Kenneth R. | Washington University | 1945 | 16 South Henry Street, Madison. |
| Prezyna, Anthony P. | University of Buffalo | 1947 | Milwaukee County Hospital, Milwaukee. |
| Roberts, Leigh M. | University of Illinois | 1947 | 1300 University Avenue, Madison. |
| Sendra, Frank R. | University of Illinois | 1928 | 9759 South Claremont Avenue, Chicago 43, Illinois. |
| Senty, Robert M. | University of Wisconsin | 1947 | 1011 North Eighth Street, Sheboygan. |
| Sowka, Albin J. | Loyola University | 1947 | 745 Main Street, Stevens Point. |
| Sutton, Charles F. | University of Chicago | 1936 | 1544 West Cook Street, Springfield, Illinois. |
| Vivino, Aurelio E. | Georgetown University | 1948 | 9010 Bradygrove Drive, Bethesda, Maryland. |
| Weissler, Joseph B. | St. Louis University | 1948 | 1011 North Eighth Street, Sheboygan. |
| Wright, Eugene N. | Hahnemann Medical College | 1943 | 46 Washington Boulevard, Oshkosh. |

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners on the dates indicated.

| *Name* | *School of Graduation* | *Year* | *Address* |
|---|---|---|---|
| Amador, Luis V. 2/24/54 | Northwestern University | 1945 | 25 East Washington, Chicago, Illinois. |
| Bakaleinik, Maurice 2/9/54 | University of Brussels | 1938 | VA Hospital, Altoona, Pennsylvania. |
| Munro, Burton S. 2/18/54 | Harvard Medical School | 1930 | Box 455, Hayward. |

The following physicians were granted licenses by a special reciprocity meeting of the State Board of Medical Examiners held in Milwaukee, February 28, 1954.

| *Name* | *School of Graduation* | *Year* | *Address* |
|---|---|---|---|
| Edelblute, Lyle H. | University of Kansas | 1945 | Bellin Memorial Hospital, Green Bay. |
| Kendrick, Richard L. | University of Pennsylvania | 1945 | Monroe Clinic, Monroe. |
| Markovitz, Jack M. | University of Illinois | 1947 | 1408 Washington Avenue, Racine. |
| Sandell, Samuel T. | University of Minnesota | 1937 | Middle River Sanatorium, Hawthorne. |

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Madison, January 12 through 14, 1954.

| *Name* | *School of Graduation* | *Year* | *Address* |
|---|---|---|---|
| Asplund, Merne W. | University of Wisconsin | 1952 | Infirmary, NAS, Olathe, Kansas. |
| Barrette, Antoine | Marquette University | 1953 | 132 North Emery Street, Peshtigo. |
| Berteau, Beatrice A. | Loyola University | 1952 | 1742 South 52nd Street, West Milwaukee. |
| Carolan, John J. | Loyola University | 1952 | 1742 South 52nd Street, West Milwaukee. |
| Cloutier, Doria M. | University of Wisconsin | 1950 | 1250 Colorado Boulevard, Apartment 207, Denver, Colorado. |
| Demergian, Vaughn | University of Wisconsin | 1952 | 4326 Mohawk Drive, Madison. |
| Dronkert, Adrian | University of Amsterdam | 1950 | Milwaukee County General Hospital, Milwaukee. |
| Gislerud, Gunhild | University of Oslo | 1947 | Milwaukee Health Department, Milwaukee. |
| Head, James M. | University of Wisconsin | 1952 | 1300 University Avenue, Madison. |
| Hillan, Donald D. | Temple University | 1949 | Milwaukee Children's Hospital, Milwaukee. |
| Huffer, John C. | University of Chicago | 1952 | 2119 Regent Street, Madison. |
| Javid, Manucher | University of Illinois | 1946 | 1300 University Avenue, Madison. |

| *Name* | *School of Graduation* | *Year* | *Address* |
|---|---|---|---|
| Kratochvil, Clyde H. | University of Wisconsin | 1952 | 1300 University Avenue, Madison. |
| Loveland, Pearl M. | University of Wisconsin | 1953 | 110 East Main Street, Madison. |
| Mueller, Carol E. | University of Wisconsin | 1952 | MacCornack Clinic, Whitehall. |
| Ninow, Earl H. | Marquette University | 1951 | 38 South Madison Street, Chilton. |
| Oudenhoven, Richard C. | Marquette University | 1952 | 3534 Woodmont, Toledo, Ohio. |
| Phillips, Morton F. | Marquette University | 1953 | 4273 North Sherman Boulevard, Milwaukee. |
| Pizer, Jerome A. | University of Wisconsin | 1952 | U. S. Army, Camp Lucas, Michigan. |
| Polcyn, Benedict M. | University of Michigan | 1952 | 3321 North Maryland Avenue, Milwaukee. |
| Radai, Joseph L. | University of Pennsylvania | 1952 | 408 Greenfield Avenue, Milwaukee. |
| Robinson, Hurley | Northwestern University | 1952 | 1453 South 92nd Street, Milwaukee. |
| Satter, Erby J. | University of Wisconsin | 1952 | 925 Mound Street, Madison. |
| Stahl, George W. | University of Wisconsin | 1950 | 1004 South Prior, St. Paul, Minnesota. |
| Standard, Anna L. T. | Howard Medical College | 1952 | 440 West Galena Street, Milwaukee. |
| Sullivan, Martin R. | Loyola University | 1952 | 1300 University Avenue, Madison. |
| Topinka, Walter A. | Ohio State University | 1952 | Box 144, Muskego. |
| Walters, Cornelius J. | Loyola University | 1952 | 1300 University Avenue, Madison. |
| Weygandt, James L. | Western Reserve University | 1952 | 611 North 89th Street, Milwaukee. |

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# The Journal Bookshelf

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry, and many others.

Address as follows: Medical Library Service. Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

**Pediatrics.** By L. Emmett Holt, Jr., professor of pediatrics, New York University College of Medicine, and director, Children's Medical Service, Bellevue Hospital, New York; and Rustin McIntosh, Carpentier professor of pediatrics, Columbia University, and director of the pediatric service in the Babies Hospital, New York. Twelfth Edition. New York, Appleton-Century-Crofts, Inc.

This well-established textbook of pediatrics has now gone through the twelfth edition. It has been greatly enlarged, completely revised, and is an excellent reference book for all general practitioners and for specialists in child care. Many authorities have contributed their information on various subjects, making much of the information up-to-date. Some of the more classical references in the literature are retained, but newer references are also included in order to make the individual sections much more useful to the student of medicine.

Especially good are some of the sections devoted to nutritional disturbances and metabolic diseases in children. A new feature of the book is the appendix, which includes much information on the normal growth and development of children, on various laboratory studies, and on instructions for parents of diabetic children. A list of household poisons and their sources, with principal symptoms and antidotes, is also given. Important aspects of preventive child care and information on the latest approach to immunizations are provided in the appropriate chapters. While some of the color photos leave something to be desired, this book is a must reference for the physician's library—H.A.W.

**Salt and the Heart.** By E. T. Yorke, M. D., attending cardiologist, Alexian Brothers' Hospital, associate cardiologist, St. Elizabeth Hospital, dispensary physician, Elizabeth General Hospital, Elizabeth, N. J.; consultant in medicine, Rahway Hospital, Rahway, N. J. Linden, N. J., Drapkin Books, 1953. Price $3.45.

This book is written for the patient who has been given a low salt diet and explains the historical background of the diet, its value, and how to follow it. In general terms, the effect of salt in the body during health, pregnancy, hypertension, and heart failure is explained; and the reason for salt restriction is made clear enough for the average patient. The treatment of congestive failure, including treatment with digitalis, mercurial diuretics, and resins is discussed; and such points as effectiveness and undesirable side effects are included. Controversial aspects of the resin therapy and rice diet are discussed in a manner that might well make the patient lose confidence in their efficacy.

Much of the last portion of the book is derived from the Mead Johnson tables and presents, in list form, sodium contents of various foods. This part of the book can be used as a reference for conscientious patients attempting to modify their diet to include foods not listed on a specific diet furnished by the physician, or instead of a diet list.

Medically trained personnel will find little of value in this book but may recommend it to their patients, recognizing that some controversial material is discussed.—G.G.R.

**Managing Your Coronary.** By William A. Brams, M. D. Philadelphia and New York, J. B. Lippincott Company, 1953. Price $2.95.

This small book is written for the layman. It is well written despite the difficulty of expressing medical terms for public understanding, albeit more than one reading is necessary for an adequate grasp. The discussion on the problems of coronary disease and "coronary thrombosis," along with the pros and cons of the theories of causation, is good and factually correct. Heart physiology, the mechanism of the heart's action, and rationale of therapy are well delineated. Above all, the attempt to allay fear and instill hope is worthwhile.

An assist from the physician in understanding the book is needed to qualify it for the patient.—H.H.S.

**Cure Your Nerves Yourself.** By Louis E. Bisch, M. D., Ph. D. New York, Wilfred Funk, Inc., 1953. Price $3.50.

This small volume is one of several books by this same author, all dealing with psychiatric matters and written primarily for the layman. In writing this book it is the author's intention to aid the

reader in better understanding himself and the various factors which contribute to emotional disturbances in his daily life. Furthermore, he makes various suggestions for attaining better adjustment and happiness in life.

In general, the book is written in an easy and readily digestible form. Although the trained psychiatrist might take issue with a number of the author's comments and conclusions, it is probable that the laity will find much of the author's information and advice reassuring and helpful. Accordingly, this book may be recommended with few reservations to the audience for which it was designed.—T.H.L.

**Living with a Disability.** By Howard A. Rusk, M. D., and Eugene J. Taylor, in collaboration with Muriel Zimmerman, O. T. R., and Julia Judson, M. S. The Institute of Physical Medicine and Rehabilitation, New York University—Bellevue Medical Center. Garden City, New York, The Blakiston Company, Inc., 1953. Price $4.00.

This is probably one of the handiest, most practical little books that has been published in recent years. It is the result of an effort over many years by Doctor Rusk and his co-workers to collect gadgets which are helpful in adjusting the disabled individual to the requirements of daily life and his job. Through a grant from the National Foundation for Infantile Paralysis and the aid of the Disabled Homemakers Research fund, this material is now made available in book form.

There is a delightful introductory chapter advising the would-be inventor of devices for the handicapped how to go about making a useful product. All of us know that these devices often have to be adapted to the individual patient. One of the valuable features of this book is that it gives typical instances from which the local inventor and gadgeteer can carry on. The clear illustrations and diagrams contribute to the book. One may well want to put this book into the hands of local "inventors" to stimulate their own ingenuity.

It is to be hoped that this book will be the first of a series, as suggestions from others, possibly stimulated by this volume, will come in to the Institute of Physical Medicine and Rehabilitation to be added to the obviously ingenious ideas from there.

The author gratefully acknowledges the help of many, not the least important of whom are the patients "who have so willingly assisted both with their ideas and in the testing of these suggestions."

Truly this is an intensely practical, useful, and stimulating book; and all of us who deal with rehabilitation problems will be grateful to the authors for having made the very considerable effort to collect, select, and publish this material.—H.D.B.

**The Medical Clinics of North America.** Philadelphia Number. Philadelphia and London, W. B. Saunders Company, 1953.

This number of the Medical Clinics of North America is dedicated to Dr. O. H. Pepper and is devoted primarily to clinical problems, although there are several "philosophical" papers and one on a mechanical heart-lung apparatus used on experimental animals. The latter paper may have some minor merit because of the pertinence of this subject today, but it is poorly chosen for such a book. The three short papers by prominent authors on more "philosophical" subjects ("The Placebo and the Physician"; "Some Thoughts on Medical Trends"; and "The Physician, the Patient, and Disease") are timely and interesting.

The bulk of this issue is related to broad topics in clinical medicine such as the management of arterial hypertension, the cardiovascular system in kidney disease, management of chronic ulcerative colitis, evaluation of fatigue and nervousness, amebiasis treatment, silicosis, collagen disease, chemotherapy, leukemia, and hemocytopenic drug reactions. These papers, forming the most important function of such a book; namely, to give the practitioner of medicine a grasp of current trends in some important aspects of medicine, are all well written and well worth reading. The rather perfunctory handling of the recent important advances in hypotensive therapy is disappointing and will do little toward guiding the therapist, however. The paper on fatigue and nervousness is particularly well done and valuable. The handling of silicosis, collagen diseases, and the chemotherapy of leukemia are especially laudable for their synthesis of basic background information and clinical manifestations. The role of allergy in cardiovascular disease is grossly overdone in another contribution to this volume in which it is stated that "at least 25% of patients with paroxysmal auricular tachycardia have had food allergy as a major factor. . . .", "if a few small doses (0.3 cc.) (of epinephrine) cause marked relief (of cardiac asthma) then an allergic factor is likely to be present."

In general, this issue contains some interesting and useful contributions and will be profitably read by general practitioners, internists, and students.—W.P.D.

**Therapeutics in Internal Medicine.** Edited by Franklin A. Kyser, M. D., F. A. C. P., assistant professor of medicine, Northwestern University Medical School, Chicago; attending physician, Evanston Hospital, Evanston, Illinois. Second Edition. New York, Paul B. Hoeber, Inc., 1953. Price $15.00.

This text is devoted to treatment of medical diseases. There are more than 80 contributors to this volume, most of whom are recognized authorities in their fields. There is no question but that this text is of value to the medical student and practicing physician wishing to learn or to review reasonably current advice and opinion regarding treatment of medical disorders. This, the second edition, even including common neurological and skin disorders, is considerably more complete in its coverage of the medical field than is the first edition—T. H. L.

*Facts about*

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## Meetings for Office Secretaries

Wisconsin Physicians Service is scheduling a series of "information sessions" for physicians' office secretaries and aides during June and August.

These meetings will provide doctors' aides with an opportunity to learn about the purposes and services of Blue Shield of Wisconsin and to understand the administrative processes and requirements of the plan.

Equally important, it is an opportunity for those in physicians' offices who deal with patients and handle Blue Shield claim forms to discuss any practical problems or questions that arise in patient contacts and reporting services rendered to persons covered by Blue Shield.

The sessions are under the immediate direction of Mr. Byron C. Ostby, field secretary of the State Medical Society. He will send notices of the meetings to all physicians in the immediate area of each meeting as it is scheduled. Physicians are urged to make arrangements for the attendance of their secretaries and office personnel who deal with Blue Shield patients and claims.

Meetings will also be arranged by Wisconsin Physicians Service upon request.

## Don't Risk a Breakdown

Every doctor knows that office paper work moves more efficiently when the person charged with handling accounts "knows the ropes." Physicians who have hired new assistants during the past year should make sure these people attend the Blue Shield "information sessions" when they are held in the area. If this isn't convenient, please contact the Wisconsin Physicians Service office (address below), and the field secretary service will either provide basic material by mail or arrange a personal visit to familiarize new employees with Blue Shield reporting procedures.

## Claims for Anesthesia Service

The Claims Department of Wisconsin Physicians Service offers a suggestion for reporting anesthesia services that may speed payment of claims and minimize correspondence.

Under Blue Shield of Wisconsin, benefits are payable when anesthesia is associated with surgical or maternity services and when performed and billed by a physician.

Physicians who render anesthesia to Blue Shield subscribers are requested to report this to Blue Shield immediately after performing the service. Use the regular Home and Office PSR forms. If you do not have a supply, send your request to WPS, and the forms will be forwarded at once.

As soon as you perform an anesthesia service on a patient with Wisconsin Physicians Service coverage, fill out the PSR with:

1. The name of the patient.
2. The name of the subscriber.
3. WPS group number and contract number.
4. Date anesthesia was administered.
5. The time in minutes.
6. Either the name of the surgeon or the description of the surgery performed. (This is needed to associate the anesthesia payment with the proper surgical case).

Then forward the PSR to Wisconsin Physicians Service at once. As soon as information is received assuring that the claim is in order, Blue Shield will process your claim for anesthesia service without further checking or delay.

In addition, when you sign the PSR, would you also sign your doctor code number behind your name? This will further speed the handling of your claim by eliminating the necessity for Blue Shield to look up your code number.

Incidentally, the basic information about the name of the subscriber and WPS group and contract numbers can be obtained from the subscriber's Blue Shield identification card. If the patient is hospitalized, the hospital business office will have this information.

For information or advice

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# PHYSICIANS' EXCHANGE

**Advertisements for this column must be received by the 25th of the month preceding month of issue. A charge is made of $2.00 for the first appearance of copy occupying 1 inch or less of space and $1.00 for each succeeding insertion of the same copy. Kindly accompany copy with remittance to cover number of insertions desired. Advertisements from individual members of the State Medical Society will be accepted without charge. The charge quoted previously applies to advertisements placed by clinics. Such copy will be taken out after its second publication unless otherwise requested. Where numbers follow advertisements replies should be addressed in care of The Wisconsin Medical Journal.**

WANTED: Doctor to practice in small agricultural and industrial community of 5,500 in southwestern Wisconsin as associate of physician with large general practice. Surgical training preferred. Complete x-ray and laboratory facilities in office. Hospital facilities in town. Address replies to Box 523 in care of the Journal.

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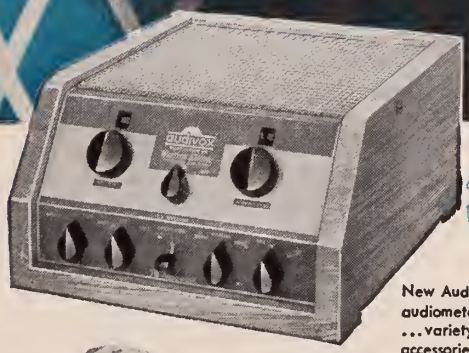

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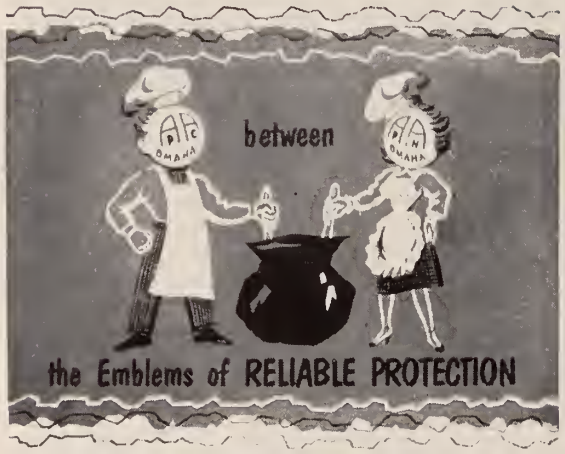


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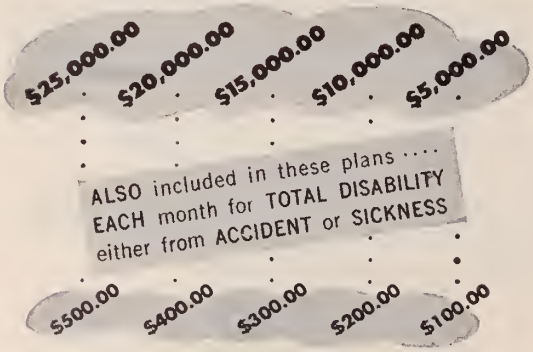


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THE WISCONSIN MEDICAL JOURNAL

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Volume 53 JULY 1954 Number 7

# Vascular Complications of Pregnancy*

By JASON H. COLLINS, M. D., and HIRAM W. K. BATSON, M. D.**
New Orleans, La.

HEMORRHAGE, sepsis, and toxemia are the major complications of pregnancy; and most maternal deaths in this country are their direct or indirect sequelae. Heart disease, anesthesia, and embolism, next in importance, contribute heavily to the present maternal mortality rate. Much basic and clinical effort has been constantly directed to decreasing or eliminating these complications; but in spite of antibiotics, blood transfusions, hospital units, trained obstetricians, prenatal clinics, anticoagulants, and surgical technics, the death rate from these factors is still appreciable.

There is no doubt that modern medical facilities and therapy have decreased the dangers of pregnancy, but unfortunately they may introduce complications of their own. One need only mention drug allergies or sensitivities, or blood transfusion reactions to emphasize this point.

### Blood Transfusion Reactions

Blood transfusions, though life saving, may in turn kill. Judicious employment is urged. Reactions, with resulting lower nephron nephrosis, are not infrequent, even under the best conditions. This entity may result from other factors as well. Our management of lower nephron nephrosis is as follows: Once the signs and symptoms of impaired kidney function develop, no more blood is given. Fluid intake per 24 hours is limited to 1,000 cc. of 5 per cent glucose given intravenously, plus the amount of the renal output. We do not give saline until the period of diuresis ensues, and this may be from 5 to 15 days after the initial renal damage. Electrocardiograms are taken periodically to aid in evaluating potassium needs. With this regime, we have had good results with the majority of our cases of lower nephron nephrosis.

### Afibrinogenopenia

Incoagulability of blood is seen infrequently in women but most often when they are pregnant. It is one of the major complications of abruptio placentae, with an outcome that is usually fatal.[1] The use of fibrinogen is specific, but unfortunately the supply of this substance is limited. We have observed this phenomenon following massive hemorrhage in all stages of pregnancy or delivery, as a complication of surgery, as a part of transfusion reactions, or as a sequela of amniotic fluid embolism. Studies of these cases have shown decreased circulating fibrinogen or the presence of a circulating fibrinolysin. Clot formation and clot lysis tests may detect the defect in blood clotting in these cases. As mentioned before, fibrinogen administration of 4 to 12 Gm. is a specific cure, but most hospitals do not have it available. Fresh whole blood by direct transfusion may be efficacious, and the use of the "dry bag" transfusion technic may simplify the problem of administering unmodified blood. It is hoped that the supply of fibrinogen will increase shortly and thus help to prevent some of these hemorrhagic deaths.

### Blood Vessels

Pulmonary embolism is a frequent cause of death in obstetric patients. We had 20 maternal deaths on the Tulane Unit at Charity Hospital in New Orleans in the period from January 1, 1949, through December 31, 1952. During that period of time we had 16,207 deliveries on the unit (Table 1).

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Seven of the twenty deaths were due all or in part to some type of pulmonary embolism or complications thereof. The remaining deaths were due to sepsis; hemorrhage; toxemia; anesthesia; and, in one instance, self-administered poison (Table 2).

It is seen from Table 3 that the types of embolism included amniotic fluid; air; embolism from phlebothrombosis; and, in one instance, embolism from suppurative pelvic thrombophlebitis complicating miliary tuberculosis. While not observed or diagnosed to date on our service, other types of embolism such as oil, fat, or bone marrow may occur in the pregnant woman and prove fatal.

TABLE 1—*Deliveries, Charity Hospital of Louisiana at New Orleans, Tulane Service, January 1, 1949, through December 31, 1952*

| | |
|---|---|
| Deliveries | 16,207 |
| Deaths | 20 |
| Maternal Mortality | 0.123% (1.23/1000) |

## Phlebothrombosis

Phlebothrombosis is described as a loosely attached bland clot in the lumen of a vein. Massive pulmonary embolism is attributed to this type of intravenous clotting. It may occur in the ambulatory individual but is more commonly seen in bedridden or postoperative patients. Phlebothrombosis may occur in pregnancy and is more common during the puerperium. The signs and symptoms of this entity are few, and no clinical or laboratory evidence may be present prior to an embolic episode. Ambulation when possible, leg and foot and toe exercises when the patient is confined to bed, are measures believed to help prevent the occurrence of this type of intravenous clotting. Daily palpation along the course of the veins of the lower extremity, examination for the presence of Homans' sign and for calf tenderness are required daily, or more often, if one is to make an early diagnosis. Observation of the pulse rate is of importance; and, with an unexplained elevation, the observer may be alerted to institute early treatment. Sometimes a small embolus may precede a more massive one and if detected early enough, specific therapy may prove lifesaving. It is to be noted here that accurate history taking and notation are essential in revealing to the attendant any previous episodes of intravascular clotting or embolism in any patient who is pregnant, confined to bed, or subjected to surgery or delivery. Such a history categorizes a patient as a clot former. Such people have a high incidence of recurrences of intravascular clotting.

TABLE 2—*Tulane Service, Charity Hospital*

Cause of Death
January 1, 1949, through December 31, 1952

| | |
|---|---|
| Embolism | 7 |
| Hemorrhage | 5 |
| Toxemia | 3 |
| Anesthesia | 1 |
| Poison (Self-Administered) | 1 |
| Pancreatitis | 1 |
| Sickle Cell Crisis | 1 |
| Ruptured Uterus and Peritonitis | 1 |
| Total | 20 |

Present therapy of phlebothrombosis includes the use of anticoagulants or vein ligation or both. When we diagnose phlebothrombosis of the lower extremity, bilateral superficial vein ligation is done. If at the time of exposure of the femoral vessels, the clot is found to extend into the iliac vein, inferior vena cava ligation is performed. We had two patients in whom clots extended above Poupart's ligament. The clots were aspirated and the superficial femorals tied. Several days later these two women died from fatal pulmonary embolism evidently due to reformation of the clot above the point of ligature; therefore, we now advocate inferior vena cava ligation rather than aspiration for clots extending into the iliac vein. Young has reported on one such case done during pregnancy.[2]

TABLE 3—*Tulane Service Charity Hospital Embolic Deaths (Maternal)*

| | | |
|---|---|---|
| Amniotic Fluid | 3 | 15 per cent |
| Air Embolism | 1 | 5 per cent |
| Embolism from Phlebothrombosis | 2 | 10 per cent |
| Suppurative Pelvic Thrombophlebitis and Miliary Tuberculosis | 1 | 5 per cent |
| Total Embolic Deaths | 7 | 35 per cent |

(35 per cent of 20 Maternal Deaths Due to Embolism)

Whether ligation or anticoagulant therapy is superior remains unsettled. The main point is that phlebothrombosis must be constantly kept in mind as a complication in obstetrics, and it is only by continual observation and prompt institution of one or both methods of therapy that one will prevent fatal embolism. Under our present regimen of observation, prophylactic measures, and prompt treatment, the incidence of fatal pulmonary embolism on our service has decreased.[3]

### Thrombophlebitis

Thrombophlebitis, or phlegmasia alba dolens, is a second type of intravascular clotting characterized by a firm, adherent intravenous clot with clinical manifestations that are obvious. Conversely to phlebothrombosis, which seldom produces temperature elevation or obvious leg signs, thrombophlebitis is characterized by high fever, leg pain, edema, and marked arteriospasm of the vessels of the affected leg. The sequelae of this process are usually local. Massive embolism—in fact, embolism itself—seldom occurs.[4]

The most effective therapy in our hands has been lumbar sympathetic block. Early employment of this technic results in a dramatic decrease in clinical signs and immediate relief of pain. Anticoagulants and antibiotics have been reported as equally efficacious, but we believe that lumbar blocks are superior.

### Suppurative Pelvic Thrombophlebitis

Suppurative pelvic thrombophlebitis is a third form of intravascular clotting mechanism responsible for a large number of postabortal and puerperal complications on our service. It is characterized by infected suppurative clots in the pelvic veins. It may occur entirely independently of thrombosis of the legs. Debility or death which may result from this process are not due to massive embolism but to the end results of small septic emboli to vital organs, including heart valves, lungs, kidneys, brain, and major blood vessels.

This complication may follow pelvic surgery, pelvic trauma, abscesses, or radium application but more commonly follows abortion or delivery, particularly if it is instrumental (Table 4).

Suppurative pelvic thrombophlebitis is usually manifested by a history of chills or rigors. The presenting symptoms may be entirely pulmonary; *i.e.*, cough, chest pain, or hemoptysis. Characteristically, the pulse is elevated and remains so in spite of the temperature variations. This has been our most reliable clinical sign. Physical findings are not remarkable in most instances. The patient may appear very well in spite of the temperature graph showings and pulse rate. Chest findings may be entirely absent even if infarction has already occurred. Pleural effusion may or may not be present; and, if it is present, there are no characteristic findings. Abdominal findings are usually absent. Ileus may be present, or signs of pelvic peritoneal irritation may be noted. Occasionally, tenderness can be elicited along the course of the ovarian veins. This finding may be confusing and lead to a mistaken diagnosis of pyelonephritis. Pelvic examination may be diagnostic if involved veins of the vagina or broad ligament are palpable. When these veins are involved, the palpatory finding is localized tenderness over the vessels that may feel like a bag of worms, cordlike, or as a string of beads. As in other pelvic infections, occasionally a sharp rise in temperature may be noted after pelvic examination.

TABLE 4—*Suppurative Pelvic Thrombophlebitis, Ligation Inferior Vena Cava and Ovarian Vessels*

| | |
|---|---|
| Number Following Vaginal Delivery | 38 |
| Number Following Abortion | 36 |
| Number Following Cesarean Section | 8 |
| Number Following Pelvic Abscess, Surgery, Trauma, or Radiation | 20 |
| Total | 102 |

Laboratory technics are of little value. Roentgenograms of the chest may not reveal infarction even if it is present. When a shadow is demonstrable, there are no pathognomic features. Multiple shadows are occasionally seen; in one instance in our series infarction was so generalized that the impression of the roentgenologist was miliary tuberculosis. Blood findings, urinary examination, etc. are seldom helpful. Blood cultures have not been consistently positive nor have we been able to find any one organism that is responsible.

Generally speaking, the diagnosis is one of exclusion of infectious diseases and processes. The difficulty encountered in establishing the entity is shown by the fact that many of our patients were referred from the medical and surgical services, where they had been admitted with such diagnoses as bronchopneumonia, phlebitis, etc. It is only by careful history taking and day-by-day evaluation of the patients that their true disease can be diagnosed.

There is no doubt that sulfonamides, antibiotics, and anticoagulants have prevented this process or cured it after its development; but we still see many cases wherein these measures, which we term "medical," have failed. Once the diagnosis is estab-

lished, patients who fail to respond to medical therapy in four or five days, who develop infarctions while under therapy, or in whom there are definite findings of infarction on admission are treated surgically. Our surgical attack is directed at interrupting the normal venous return from the uterus, *i.e.*, from both the right and left ovarian vessels and the inferior vena cava. Previous communications have discussed the problem of etiology, diagnosis, pathology, and surgical therapy in detail.[5-9]

Since 1941 we have employed surgery in 102 cases of suppurative pelvic thrombophlebitis and have a survival of 90 patients, or 88 per cent. This was in patients who had failed to respond to medical therapy. We consider the procedure to be lifesaving.

### Phlegmasia Cerulea Dolens

Phlegmasia cerulea dolens, or acute massive venous occlusion of the lower extremities, has not been observed on our obstetrical service but has been reported by others.[10] It is characterized by such complete impediment of the blood return of the lower extremity that gangrene of the feet and toes may result. Furthermore, the patient may lose not only her limb, but also her life. The process, fortunately, is relatively rare. The process results in an acutely engorged, painful, tender extremity of a cyanotic hue. Lumbar sympathetic blocks and vasodilators are of little efficacy. Veal[10] reports that elevation of one limb with passive flexion and extension of the feet and thigh produced good results. Others advocate surgical evacuation of the thrombus as being efficacious.[11, 12]

### Amniotic Fluid Embolism

Amniotic embolism has recently been recognized as an important cause of maternal death during labor or in the immediate puerperium. This cause of death was first described by Steiner and Lushbough in 1941.[13] It is characterized by the entrance of fetal amniotic fluid and its contents; namely, meconium, squamae, mucin, lanugo hairs, and debris into the maternal circulation by way of the veins and venules of the myometrium. These are carried therefrom into the arteries and arterioles of the lung. When this occurs, the patient manifests deep shock. It is evidenced by a sudden drop in blood pressure and a cessation of radial pulse. Cyanosis and dyspnea are usually evident, and death may occur in a matter of minutes.

Nonfatal amniotic fluid embolism is believed to occur, but the diagnosis is almost impossible to prove. The occurrence of the picture described above in a patient that has been in hard or sudden labor followed by a hemorrhagic tendency may be explained on the basis of amniotic fluid in the maternal circulation. To date, the only substantiated cases of amniotic embolism reported were found at autopsy or by the method of Gross and Benz.[14] This method is urged in cases when autopsy has been refused. It consists of a postmortem drawing of blood from the right heart or inferior vena cava and centrifuging of it. Instead of just the buffy layer and clear layer above the cells, a third layer is formed. This middle layer, when fixed in block, sectioned, and stained, will show the presence of amniotic contents. One of three cases of death from amniotic fluid embolism on our service was proved by employing this method. The remaining two cases were proved at autopsy.

The autopsy findings reveal gross or microscopic evidence of amniotic contents in the uterus, ovaries, and particularly in the lungs. Though it is stated that gross evidence is impossible to detect in the lungs,[15] one of our cases had gross findings in the lungs when autopsied. The cut surface of the lungs showed numerous areas of amniotic and meconium emboli, and droplets of glistening yellow material could be expressed from the arterioles. A smear of this material showed lanugo hair and debris.[16]

Microscopically, other elements of amniotic fluid can be found in the lungs and arterioles and are usually near the periphery. There is an associated marked leucocytic reaction. Areas of emphysema and atelectasis are both seen, as in pulmonary edema.

Very recently, Reid and co-workers[17] have studied the associated phenomenon of incoagulability of blood in these cases and have attributed it to intravascular clotting and defibrination due to the amniotic fluid. The result is an afibrinogenopenia with resulting death unless fibrinogen can be obtained and administered. These authors prefer the term amniotic fluid "infusion" rather than embolism since they believe that the intravascular clotting of the blood, rather than the embolic process *per se*, produces the shocklike state.

### Air Embolism

Air embolism occurs infrequently in obstetrics and gynecology; but when it does, it is usually fatal. Sublethal air embolism probably occurs but is seldom recognized.

Air embolism results from the entrance of air into the venous or arterial circulation, occluding or partially blocking arterioles and vessels, most significantly the cerebral and coronary vessels. The end result of this process depends upon the vessels involved and the organs they supply.

In obstetrics, fatal cases have been reported following intravaginal insufflation of powders, douches, criminal abortion utilizing air as the agent, postpartum knee-chest position, tubal insufflation, manual removal of the placenta, and other manipulation during labor or delivery.

In diagnostic endeavors, it has been found to follow inflation of the urinary bladder, perirenal air insufflation for adrenal visualization, diagnostic curettage, and peritoneoscopy. Therapeutically, air embolism has been a complication in pneumoperitoneum, therapeutic dilatation and curettage, and during intravenous infusions.

The amount of air necessary to produce this complication seems to vary according to many factors including rapidity of entrance and the general condition of the subject. The mechanism of death in the venous type appears to be one or a combination of three factors: 1. Embarrassment of heart function due to the actual air bubble or to the frothing of the blood; 2. Blockage of the pulmonary artery with the frothed blood; or 3. Multiple small air emboli blocking the finer arterioles of the lung.

The signs and symptoms of this catastrophe are usually dramatic. Apprehension, dyspnea, cyanosis, and tachycardia are noted almost immediately. The pulse then becomes irregular, and the patient eventually is in shock. A peculiar gurgling, rushing heart sound has been described as diagnostic. This sound is attributed to the churning of the frothy blood in the heart chambers.

The recommended therapy is aspiration of the air from the right ventricle. To be effective, the procedure must be done almost as soon as the insult occurs; thus, prompt recognition of the phenomenon is essential. Other recommended measures are turning the patient on her left side to allow the air to rise above the level of the blood in the right heart, using forced oxygen, administering papaverine or other similar antispasmotics, giving blood and fluids intravenously, and employing other supportive measures. These are usually ineffective.

It must be emphasized that if air embolism is suspected as a cause of death, autopsy should be done. If unobtainable, the right ventricle should be aspirated as soon as possible postmortem in an effort to establish the presence or absence of air therein.[18-22]

### Summary

Vascular complications account for an appreciable number of maternal deaths despite modern facilities, technics, and therapy.

Blood transfusions are not without risk. Lower nephron nephrosis, a dreaded complication, may result; and one should exercise caution with the administration of intravenous fluids during the anuric phase of the disease. Our practice is to administer only 1,000 cc. of sodium free intravenous fluids, in addition to the urinary output, daily until diuresis ensues.

Afibrinogenopenia, although infrequent, may occur during any phase of pregnancy. Fibrinogen administration is specific; but due to the fact that fibrinogen is not generally available, direct transfusions of whole blood may be beneficial.

Seven of twenty deaths on the Tulane Unit, Charity Hospital at New Orleans, from January 1, 1949, through December 31, 1952, were due to pulmonary embolism. A massive embolism is more likely to occur as a result of phlebothrombosis because the clot is loosely attached to the vein wall. As a complication of pregnancy, its occurrence is more common during the puerperium. Early ambulation or leg and foot exercises for the bedridden patients are thought to be good prophylactic measures. Constant observations of the pulse rate and daily examination of the lower extremities for calf tenderness, tenderness along the course of the veins, or Homans' sign may enable one to make the diagnosis early. It is our policy to ligate the superficial femoral vein for phlebothrombosis of the lower extremity. Ligation of the inferior vena cava is performed if the clot extends into the external iliac vein. Under this method of management, our fatalities from pulmonary embolism have decreased.

By reason of the firm, adherent clot characteristic of thrombophlebitis, embolism is

less common. Symptoms and signs are fever, leg pain, and edema. Lumbar sympathetic blocks have been most effective in our experience.

Suppurative pelvic thrombophlebitis may follow delivery and abortion, spontaneous or instrumental, and may occur without the lower extremities being involved. Severe illness or death may result from showers of small septic emboli. A sustained fast pulse rate, "picket fence" type, out of proportion to temperature variations is characteristic. Pelvic examination may be helpful in that involved veins may be palpated; however, with involvement limited to the ovarian veins, pelvic findings may be absent. Ligation of the inferior vena cava and ovarian vessels is done on those patients who fail to respond to medical management, those who develop infarction under treatment, and those who show definite evidence of infarction on admission. Since 1941 we have employed this surgical approach in 102 cases, with a mortality rate of 12 per cent, *in patients who had failed to respond to other measures.*

Phlegmasia cerulea dolens, with resulting gangrene of the foot and toes, has not been observed on our obstetrical service. Apparently lumbar blocks and vasodilators have little effect. Surgical evacuation of the clot or the method suggested by Veal may be helpful.

Three cases of fatal amniotic fluid embolism have occurred on our service at Charity Hospital. Such cases may be substantiated at autopsy or by the method of Gross and Benz. In the light of recent studies there appears to be a relationship between afibrinogenopenia and the infusion of amniotic fluid into the maternal blood stream, and it is a matter of conjecture whether the shocklike state seen is the result of the embolism of amniotic fluid or the result of intravascular clotting of blood.

Fatal air embolism may occur after intravaginal insufflation of powders, douches, instrumental abortion, postpartum knee-chest exercises, tubal insufflation, manual removal of the placenta, and other procedures previously mentioned. The amount of air necessary to cause a fatality is not known. Death is due to the combination of the resulting embarrassment of cardiac function, blockage of the pulmonary artery, and blockage of the smaller arterioles of the lung. Anxiety, dyspnea, tachycardia, and cyanosis are immediate manifestations, with shock as a subsequent manifestation. A gurgling, rushing sound upon auscultation of the heart is diagnostic. Recommended therapeutic measures are generally ineffectual.

With the decrease of maternal deaths from such leading causes as heart disease, toxemia, infection, and hemorrhage, embolism is becoming a leading mortality factor. Constant attention to prophylaxis and the necessity for adequate therapy are emphasized.

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## BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the last half of 1954 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referral be made by the family physician; but when this is not feasible, arrangements may be made by writing to the Bureau. Forms for the purpose of referral may be obtained from the Bureau of Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify for which clinic forms are wanted.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of the fact.

| | |
|---|---|
| Eau Claire | July 29, 30 |
| Ashland | August 11, 12 |
| Wausau | August 25, 26 |
| Manitowoc | September 1, 2 |
| Marinette | September 8 |
| Kenosha | September 15, 16 |
| Green Bay | September 23, 24 |
| Superior | September 29, 30 |
| La Crosse | October 12, 13, 14, 15 |
| Racine | October 20, 21 |
| Sheboygan | October 28, 29 |
| Rhinelander | November 3, 4 |
| Eau Claire | November 11, 12 |
| Appleton | November 18, 19 |
| Fond du Lac | December 1, 2 |
| Chippewa Falls | December 9, 10 |

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

# A Study of the Possible Effect of Gamma Globulin in a Mass Inoculation Program

By R. E. GRABER, M. D., M. P. H.*
Chippewa Falls

DURING an outbreak of poliomyelitis in Wisconsin in 1953 a mass prophylactic program with gamma globulin was carried out in Polk County.

There is abundant laboratory evidence of the protective value of gamma globulin obtained from pooled blood against the three known types of poliomyelitis viruses. However, many practical difficulties restrict its use as a prophylactic weapon against outbreaks of the disease. Justification for its continued use in mass programs is not clear and must rest on further studies to evaluate its efficacy.

The writer participated in the organization and conduct of the Polk County program and was in close observation of the disease outbreak in all of its stages in the area. The purpose of this paper is to study the possible effect of gamma globulin in a mass inoculation procedure. It is realized that the conditions of an ideally controlled mass experiment such as the field trials of Hammon and others in 1952 do not exist in the present study. As a control measure in this study, epidemiological data are presented in two series, including those from Polk County and those from four adjacent counties; and cases are considered before and after the date of termination of the mass program.

### Description of the Area

Polk County is located in northwestern Wisconsin bordering the Minnesota state line, which follows the course of the St. Croix River. The 1950 census shows a population of 24,944, of whom 98.45 per cent are white. With no incorporated cities or villages as large as 2,500, the county is classified as 100 per cent rural. Its predominant industry is agriculture.

Bordering Polk County on three sides are the Wisconsin counties of Burnett, Barron, and St. Croix. Pierce County, adjoining St. Croix County on the south, was also included in the study. Population and industrial characteristics of these four counties are essentially similar to those of Polk County. Their respective populations are 10,236, 34,703, 25,905, and 21,448. Their combined total population is 92,292.

The population trend in the five counties is static. Actually, there was an 0.8 per cent decrease from 1940 to 1950. In this report, all calculations involving population figures are based on the 1950 census.

### Community Health Resources

In Polk County fifteen physicians are in active practice. There are five small general hospitals. The other four counties are served by a total of fifty-seven physicians and eleven hospitals. The bulk of poliomyelitis cases in all the counties are referred to poliomyelitis care centers outside the area. Fifty-two of the one hundred and fourteen cases received care in Minneapolis or St. Paul.

### Method of Study

A history was obtained on all cases reported in the area. The diagnosis and paralytic status were certified by the writer by one or more of three methods; *viz.*, interview with the attending physician, study of hospital record, and direct examination of the patient. In the main, diagnostic criteria were the history of a typical onset and clinical findings of neck rigidity and back and hamstring spasm. In the majority of cases, increased spinal fluid cell counts were observed; but no cases were excluded in the absence of that finding.

### Poliomyelitis Incidence

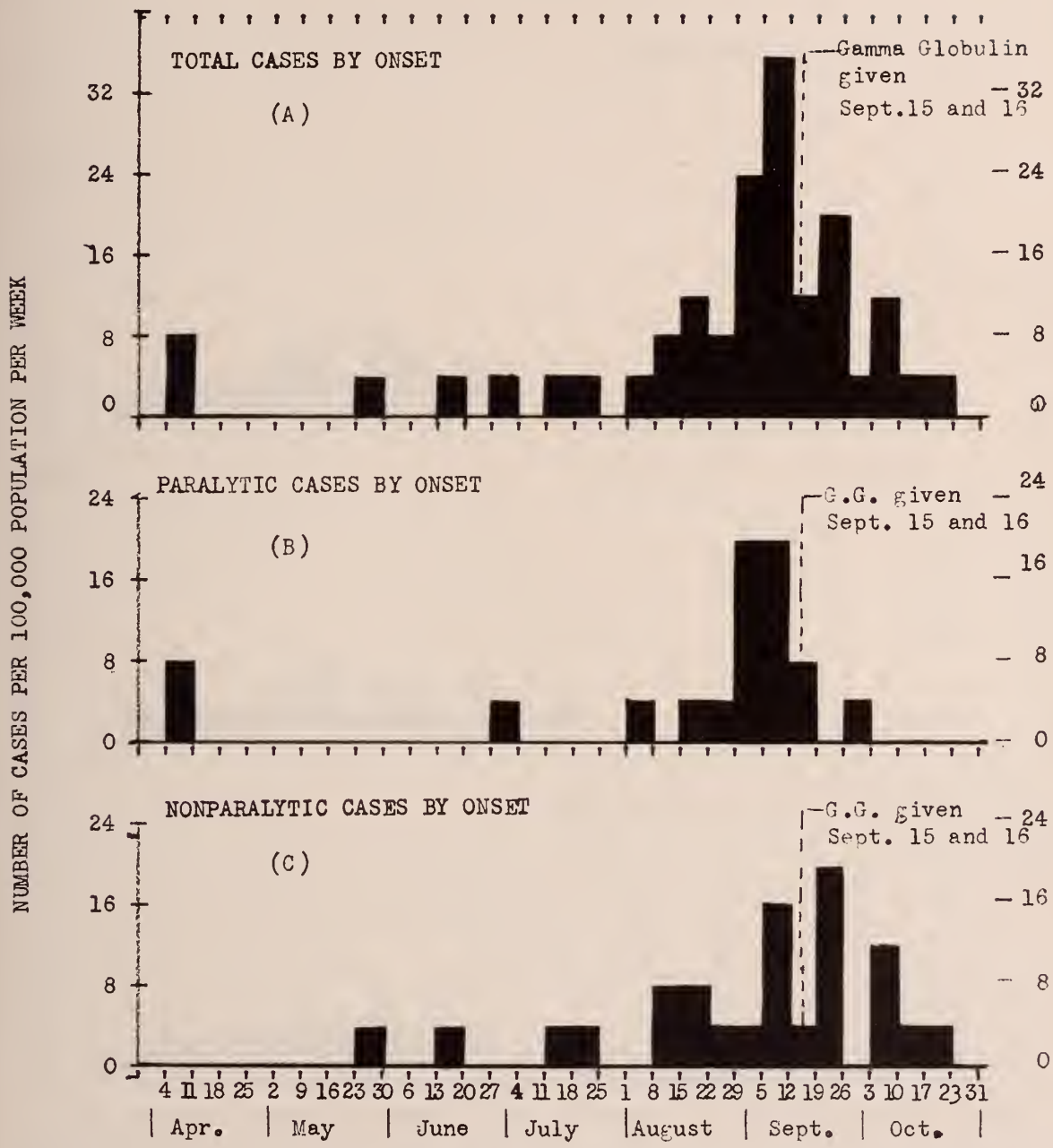
The following tables and graphs show the poliomyelitis incidence for the year 1953 up to November 1. A total of 114 cases was reported, 45 resident in Polk and 69 in the other four counties.

Age distribution and age specific attack rates are shown in Table 1. In Table 2 the cases are listed by week of onset and paralytic status; this information is also shown by the graphs in Figures 1 and 2.

*District Health Officer.

Figure 1

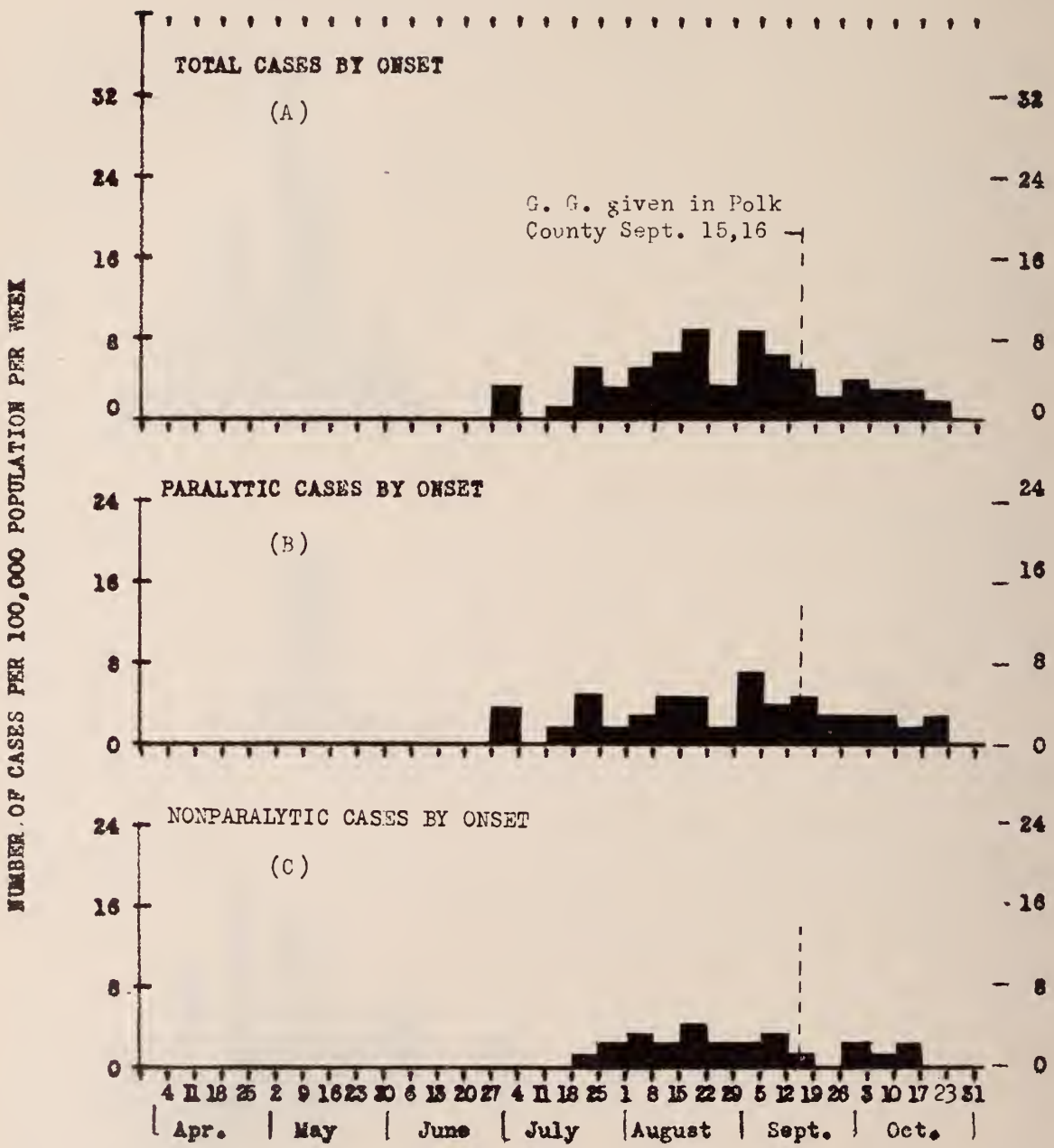
POLIOMYELITIS POLK COUNTY 1953




| Age | Before Gamma Globulin | | | After Gamma Globulin | | | Per Cent of Total Cases | |
|---|---|---|---|---|---|---|---|---|
| | Paralytic | Non-Paralytic | Total | Paralytic | Non-Paralytic | Total | Before | After |
| 0–14 | 11 | 12 | 23 | 1 | 4 | 5 | 67.6 | 45.5 |
| 15+ | 7 | 4 | 11 | 0 | 6 | 6 | 32.4 | 54.5 |
| Total | 18 | 16 | 34 | 1 | 10 | 11 | 100.0 | 100.0 |

Figure 2

POLIOMYELITIS FOUR ADJACENT COUNTIES, WISCONSIN, 1953




| Age | Before Gamma Globulin* | | | After Gamma Globulin* | | | Per Cent of Total Cases | |
|---|---|---|---|---|---|---|---|---|
| | Paralytic | Non-Paralytic | Total | Paralytic | Non-Paralytic | Total | Before | After |
| 0–14 | 19 | 14 | 33 | 5 | 3 | 8 | 60.0 | 57.1 |
| 15+ | 14 | 8 | 22 | 4 | 2 | 6 | 40.0 | 42.9 |
| Total | 33 | 22 | 55 | 9 | 5 | 14 | 100.0 | 100.0 |

* Refers to date of termination of mass program in Polk County.

Several differences are to be noted in the two series. It is at once apparent that in severity the outbreaks are not ideally comparable.

It is interesting to note the difference in the proportion of paralytic to nonparalytic cases in the two series. This item is discussed at some length here because it is deemed to be of great importance in this study.

In Table 2 it is seen that the proportion of paralytic to nonparalytic cases in the four-county "control" series over the entire period of the study was 42 to 27, or 61 to 39 percentagewise. This coincides with the 61 to 39 national average ratio for 1952,* and the Wisconsin average ratio of 58 to 42 for the five-year period, 1947–1951.**

TABLE 1—*Resident Poliomyelitis, Polk and Four Adjacent Counties, Wisconsin, 1953 up to November 1, Age Distribution of Reported Cases by Number, Percentage of Total, and Age Specific Attack Rate Per 100,000 Population*

| Age Groups | Number of Cases | | Percentage of Total | | Rate Per 100,000 | |
|---|---|---|---|---|---|---|
| | Polk County | 4 Other Counties | Polk County | 4 Other Counties | Polk County | 4 Other Counties |
| 0– 4 | 6 | 11 | 13.3 | 16.0 | 224 | 104 |
| 5– 9 | 13 | 23 | 28.9 | 33.3 | 534 | 261 |
| 10–14 | 9 | 7 | 20.0 | 10.1 | 402 | 92 |
| 0–14 | 28 | 41 | 62.2 | 59.4 | 381 | 152 |
| 15–19 | 7 | 8 | 15.6 | 11.6 | 376 | 117 |
| 20–24 | 1 | 4 | 2.2 | 5.8 | 78 | 70 |
| 25 and over | 9 | 16 | 20.0 | 23.2 | 63 | 31 |
| 15 + | 17 | 28 | 37.8 | 40.6 | 96 | 43 |
| All Ages | 45 | 69 | 100.0% | 100.0% | 180 | 75 |

The Polk County ratio for the season was 42 to 58, an inverted ratio indicating that a relatively greater number of nonparalytic cases was reported there than in the other counties. The difference must be regarded as significant and not an occurrence of chance since it represents a relative deviate equal to 2.1 standard errors of difference. A relative deviate of >2 is regarded as statistically significant.

Feig's studies further show that as an epidemic progresses and wanes, the ratio in reported cases fluctuates. The proportion of nonparalytic cases rises as the season advances and reaches its greatest magnitude at the height of the epidemic but never reaches as high as 50 per cent. It then recedes as total case incidence wanes, reaching its lowest values in October and November.

TABLE 2—*Resident Poliomyelitis in Polk and Four Adjacent Wisconsin Counties, 1953. Paralytic, Nonparalytic, and Total Cases by Week of Onset*

| Week Ending | Polk County | | | 4 Other Counties | | |
|---|---|---|---|---|---|---|
| | Paralytic | Non-paralytic | Total | Paralytic | Non-paralytic | Total |
| Prior to 6–20 | 2 | 3 | 5 | 0 | 2 | 2 |
| 6–27 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7– 4 | 1 | 0 | 1 | 3 | 0 | 3 |
| 7–11 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7–18 | 0 | 1 | 1 | 1 | 0 | 1 |
| 7–25 | 0 | 1 | 1 | 4 | 1 | 5 |
| 8– 1 | 0 | 0 | 0 | 1 | 2 | 3 |
| 8– 8 | 1 | 0 | 1 | 2 | 3 | 5 |
| 8–15 | 0 | 2 | 2 | 4 | 2 | 6 |
| 8–22 | 1 | 2 | 3 | 4 | 4 | 8 |
| 8–29 | 1 | 1 | 2 | 1 | 2 | 3 |
| 9– 5 | 5 | 1 | 6 | 6 | 2 | 8 |
| 9–12 | 5 | 4 | 9 | 3 | 3 | 6 |
| 9–19 | 2 | 1 | 3 | 4 | 1 | 5 |
| (Gamma Globulin given in Polk County September 15 and 16) | | | | | | |
| 9–26 | 0 | 5 | 5 | 2 | 0 | 2 |
| 10– 3 | 1 | 0 | 1 | 2 | 2 | 4 |
| 10–10 | 0 | 3 | 3 | 2 | 1 | 3 |
| 10–17 | 0 | 1 | 1 | 1 | 2 | 3 |
| 10–24 | 0 | 1 | 1 | 2 | 0 | 2 |
| 10–31 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 19 | 26 | 45 | 42 | 27 | 69 |
| Per Cent of Total | 42.2 per cent | | | 60.9 per cent | | |

| | Prior to and Through Week of Immunization | | | | After Week of Immunization | | | |
|---|---|---|---|---|---|---|---|---|
| | Paralytic | Non-paralytic | Total | Per Cent Paralytic Cases | Paralytic | Non-paralytic | Total | Per Cent Paralytic Cases |
| Polk County | 18 | 16 | 34 | 52.9% | 1 | 10 | 11 | 9.1% |
| 4 Others | 33 | 22 | 55 | 60.0% | 9 | 5 | 14 | 64.3% |

In Figure 5 the cumulative numbers of paralytic and nonparalytic cases in Polk County are shown by calendar week. The widest divergence between the two curves and the greatest deviation from normal occurs toward the end of the epidemic and after the gamma globulin was given, although the disproportion existed early in the course of the outbreak. Partially accounting for this is the fact that it is probably true that there was better recognition and /or more complete reporting of nonparalytic cases by Polk County physicians, who were alerted to the existence of a sizable epidemic. The latter were also cognizant of the county's proximity to eligibility for mass prophylaxis early in the course of the outbreak.

### Possible Effect of Gamma Globulin in Case Prevention

During the mass program on September 15 and 16 in Polk County, 6,715 children under 15 years of age were injected with

*Morb. & Mort. Weekly Report, Ann. Sum., Oct. 26, 1953.

**Feig, M.: Some Epidemiological Aspects of Poliomyelitis in Wisconsin, 1947–1952, Wisconsin M. J., 52:383–388 (July) 1953.

gamma globulin. This represents 93 per cent of the estimated population of 7,218 in that age group. The dosage given was 0.14 cc. per pound of body weight up to a maximum of 20 cc.

As shown in Table 2 and Figure 1, it is apparent that the mass program was not carried out until a week after the outbreak had passed its peak. In the other four counties the peak of incidence occurred at least one week earlier (Fig. 2).

In Table 5, cases are considered in number and incidence rates per 100,000 population before and after the date of termination of the mass program, comparing those in Polk County with the controls.

Table 5 (depicted graphically in Figures 3 and 4) shows that an essentially similar percentage of the total number of cases of all ages occurred after the date of termination of the mass program in the two series. The Polk County percentage is slightly higher but not sufficiently so to be statistically significant. The result fails to show that any cases were spared in Polk County.

TABLE 3—*Number of Poliomyelitis Cases Among Children Under 15 Years of Age, 1953, By Week of Onset*

| Week Ending | Polk County | | | 4 Other Counties | | |
|---|---|---|---|---|---|---|
| | Paralytic | Non-paralytic | Total | Paralytic | Non-paralytic | Total |
| Prior to 4-1 | 0 | 0 | 0 | 0 | 1 | 1 |
| 4-11 | 2 | 0 | 2 | 0 | 0 | 0 |
| 6-20 | 0 | 1 | 1 | 0 | 0 | 0 |
| 7-4 | 0 | 0 | 0 | 1 | 0 | 1 |
| 7-11 | 0 | 0 | 0 | 0 | 0 | 0 |
| 7-18 | 0 | 1 | 1 | 1 | 0 | 1 |
| 7-25 | 0 | 1 | 1 | 3 | 1 | 4 |
| 8-1 | 0 | 0 | 0 | 1 | 1 | 2 |
| 8-8 | 0 | 0 | 0 | 2 | 2 | 4 |
| 8-15 | 0 | 2 | 2 | 2 | 1 | 3 |
| 8-22 | 1 | 2 | 3 | 3 | 2 | 5 |
| 8-29 | 0 | 1 | 1 | 1 | 2 | 3 |
| 9-5 | 5 | 1 | 6 | 1 | 2 | 3 |
| 9-12 | 3 | 3 | 6 | 2 | 1 | 3 |
| 9-19 | 0 | 0 | 0 | 2 | 1 | 3 |
| (Gamma Globulin given in Polk County September 15 and 16) | | | | | | |
| 9-26 | 0 | 1 | 1 | 1 | 0 | 1 |
| 10-3 | 1 | 0 | 1 | 2 | 2 | 4 |
| 10-10 | 0 | 2 | 2 | 0 | 0 | 0 |
| 10-17 | 0 | 0 | 0 | 1 | 1 | 2 |
| 10-24 | 0 | 1 | 1 | 1 | 0 | 1 |
| 10-31 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 12 | 16 | 28 | 24 | 17 | 41 |

| | Prior to and Through Week of Immunization | | | | After Week of Immunization | | | |
|---|---|---|---|---|---|---|---|---|
| | Paralytic | Non-paralytic | Total | Per Cent with Paralysis | Paralytic | Non-paralytic | Total | Per Cent with Paralysis |
| Polk County | 11 | 12 | 23 | 47.8% | 1 | 4 | 5 | 20% |
| 4 Other Counties | 19 | 14 | 33 | 57.6% | 5 | 3 | 8 | 62.5% |

TABLE 4—*Number of Poliomyelitis Cases Among Persons 15 Years of Age and Over, 1953, by Week of Onset*

| Week Ending | Polk County | | | 4 Other Counties | | |
|---|---|---|---|---|---|---|
| | Paralytic | Non-paralytic | Total | Paralytic | Non-paralytic | Total |
| Prior to April 1 | 0 | 1 | 1 | 0 | 1 | 1 |
| May 30 | 0 | 1 | 1 | 0 | 0 | 0 |
| July 4 | 1 | 0 | 1 | 2 | 0 | 2 |
| 18 | 0 | 0 | 0 | 0 | 0 | 0 |
| 25 | 0 | 0 | 0 | 1 | 0 | 1 |
| Aug. 1 | 0 | 0 | 0 | 0 | 1 | 1 |
| 8 | 1 | 0 | 1 | 0 | 1 | 1 |
| 15 | 0 | 0 | 0 | 2 | 1 | 3 |
| 22 | 0 | 0 | 0 | 1 | 2 | 3 |
| 29 | 1 | 0 | 1 | 0 | 0 | 0 |
| Sept. 5 | 0 | 0 | 0 | 5 | 0 | 5 |
| 12 | 2 | 1 | 3 | 1 | 2 | 3 |
| 19 | 2 | 1 | 3 | 2 | 0 | 2 |
| (Gamma Globulin given in Polk County September 15 and 16) | | | | | | |
| Sept. 26 | 0 | 4 | 4 | 1 | 0 | 1 |
| Oct. 3 | 0 | 0 | 0 | 0 | 0 | 0 |
| 10 | 0 | 1 | 1 | 2 | 1 | 3 |
| 17 | 0 | 1 | 1 | 0 | 1 | 1 |
| 24 | 0 | 0 | 0 | 1 | 0 | 1 |
| Total | 7 | 10 | 17 | 18 | 10 | 28 |

Table 5 also compares results in the under 15 age group which received gamma globulin in Polk County with results in controls of the same age. Of the 28 cases in Polk County, 5 occurred after gamma globulin was given. The five cases represent 17.9 per cent of the total for the year in that age group. In the controls, 8 out of a total of 41 occurred during the period following the program, for a percentage of 19.5 per cent. The slight difference in favor of Polk County is not statistically significant. There is no evidence, therefore, that the mass inoculation procedure in Polk County had a preventive effect in reducing incidence of poliomyelitis in the age group which received gamma globulin.

## Possible Modifying Effect of Gamma Globulin in Preventing or Reducing Paralytic Symptoms

Paralytic cases are considered in Table 6. In attempting to determine the possible modifying effects of gamma globulin in preventing or reducing paralytic manifesta-

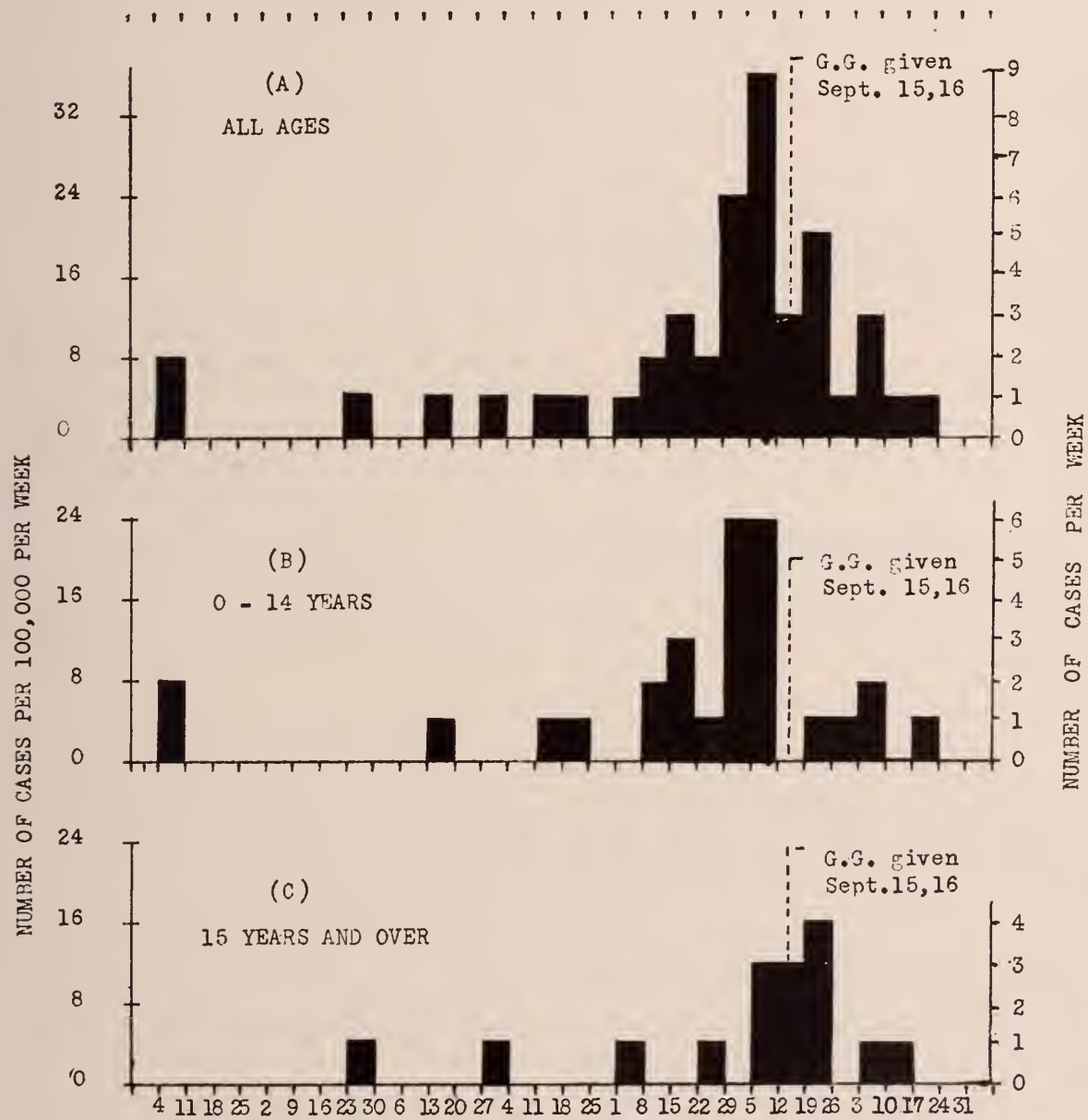
TABLE 5—*Total Cases by Age Groups—Before and After Program*

| | Total | | Before | | After | | |
|---|---|---|---|---|---|---|---|
| | Cases | Rate | Cases | Rate | Cases | Rate | Per Cent After |
| Polk County | | | | | | | |
| All Ages | 45 | 180 | 34 | 136 | 11 | 44 | 24.4 |
| Under 15 | 28 | 381 | 23 | 313 | 5 | 68 | 17.9 |
| 15+ | 17 | 96 | 11 | 62 | 6 | 34 | 35.3 |
| Controls | | | | | | | |
| All Ages | 69 | 75 | 55 | 60 | 14 | 15 | 20.3 |
| Under 15 | 41 | 152 | 33 | 122 | 8 | 30 | 19.5 |
| 15+ | 28 | 43 | 22 | 34 | 6 | 9 | 21.4 |

Figure 3

POLIOMYELITIS POLK COUNTY 1953

CASES BY AGE GROUP AND WEEK OF ONSET




tions, we have only five cases available for consideration, since that was the total number which developed polio after receiving gamma globulin (Table 6). Of these only one developed paralysis.* In the same group of the controls, there was a total of eight cases, of which five were paralytic. Although the contrast is striking, it cannot be considered significant since the total number in both groups was so small (13). It is only possible to state that gamma globulin does not prevent paralytic incidence in all cases.

Disregarding the inadequate number of cases, another result which might be interpreted as a globulin effect in the Polk County

*It is of interest to note here that the single case in question was one of moderate severity in an eleven-year-old boy whose first symptoms occurred exactly two weeks following his inoculation with gamma globulin.

TABLE 6—*Total and Paralytic Cases. All Ages and Under 15. Before and After Program*

| | Before | | | After | | |
|---|---|---|---|---|---|---|
| | Total Cases | With Paralysis | Per Cent With Paralysis | Total Cases | With Paralysis | Per Cent With Paralysis |
| Polk County | | | | | | |
| All Ages | 34 | 18 | 52.9 | 11 | 1 | 9.1 |
| Under 15 | 23 | 11 | 47.8 | 5 | 1 | 20.0 |
| Controls | | | | | | |
| All Ages | 55 | 33 | 60.0 | 14 | 9 | 64.3 |
| Under 15 | 33 | 19 | 57.6 | 8 | 5 | 62.5 |

under 15 age group is illustrated in Table 6. That is the decrease in the proportion of paralytic to nonparalytic cases, due to a relative increase in the latter as compared with the controls. This increase is shown in Table 7.

The relative increase in nonparalytic cases in the Polk County group that received globulin is shown by comparing the percentages given in Table 7—25 per cent in Polk County and 17.6 per cent in the control counties.

An unexpected result is discovered in comparing the +15 age groups. Here it is seen that percentage incidence of nonparalytic cases was much greater in Polk County after the program than in the control counties. This is not consistent with a globulin effect since that age group did not receive globulin.

Projecting the difference in nonparalytic case incidence to the totals of all ages shows a percentage of 38.5 in Polk County and 18.5 in the control counties. This difference is statistically significant. As pointed out above, it is not due to gamma globulin; and another cause must be sought.

For this purpose a chronological account of the behavior of the paralytic to nonparalytic case ratio is presented in Figure 5 by graphing its components.

In a normal ratio, the nonparalytic curve would occupy a position below the paralytic curve. It would have a concentric relationship except for a minor bulge at the height of the season, followed by a recession.

Figure 5 shows that as case incidence begins to mount, the nonparalytic line abandons the form of a normal parabolic curve, becomes erratic, and remains above its normal position. The greatest divergence begins on the week following the mass program and attains a magnitude exceeding that required to constitute statistical significance.

The people of Polk County began to feel concern over the increasing case load early in the season. The restricted availability of gamma globulin for use in family contacts only increased their concern. They wanted it for everybody. In one community a meeting of representative citizens was held to investigate methods of procuring it. A few days later the county became eligible for mass inoculation. The procedure itself was highly dramatic. In addition to the 7,000 lollipop recipients, several hundred citizens participated in a community effort to organize and conduct the project in order to bring about the speedy and successful fruition of its purpose.

Psychological impact and stress are not easily measured. However, their results are apparent. As a possible example, witness the phenomenal incidence of nonparalytic cases in the +15 age group the week following the program (Fig. 3, C). Not having received globulin, those persons did not have a recourse in the fancied belief that they were protected. Figure 5 shows the broken-line curve of nonparalytic case incidence as reported by physicians. It might well be also the broken-line curve of the product of such factors as public agitation and professional solicitude.

## Summary and Conclusions

1. During 1953, up to November 1, a total of 114 cases of poliomyelitis occurred in five contiguous Wisconsin counties. Of the 114 cases, 45 were resident in Polk County and 69 in four adjacent counties.

2. Gamma globulin was administered to 93 per cent of the children under 15 years of age in Polk County on September 15 and 16.

3. Epidemiological data from Polk County are compared with the aggregate of those

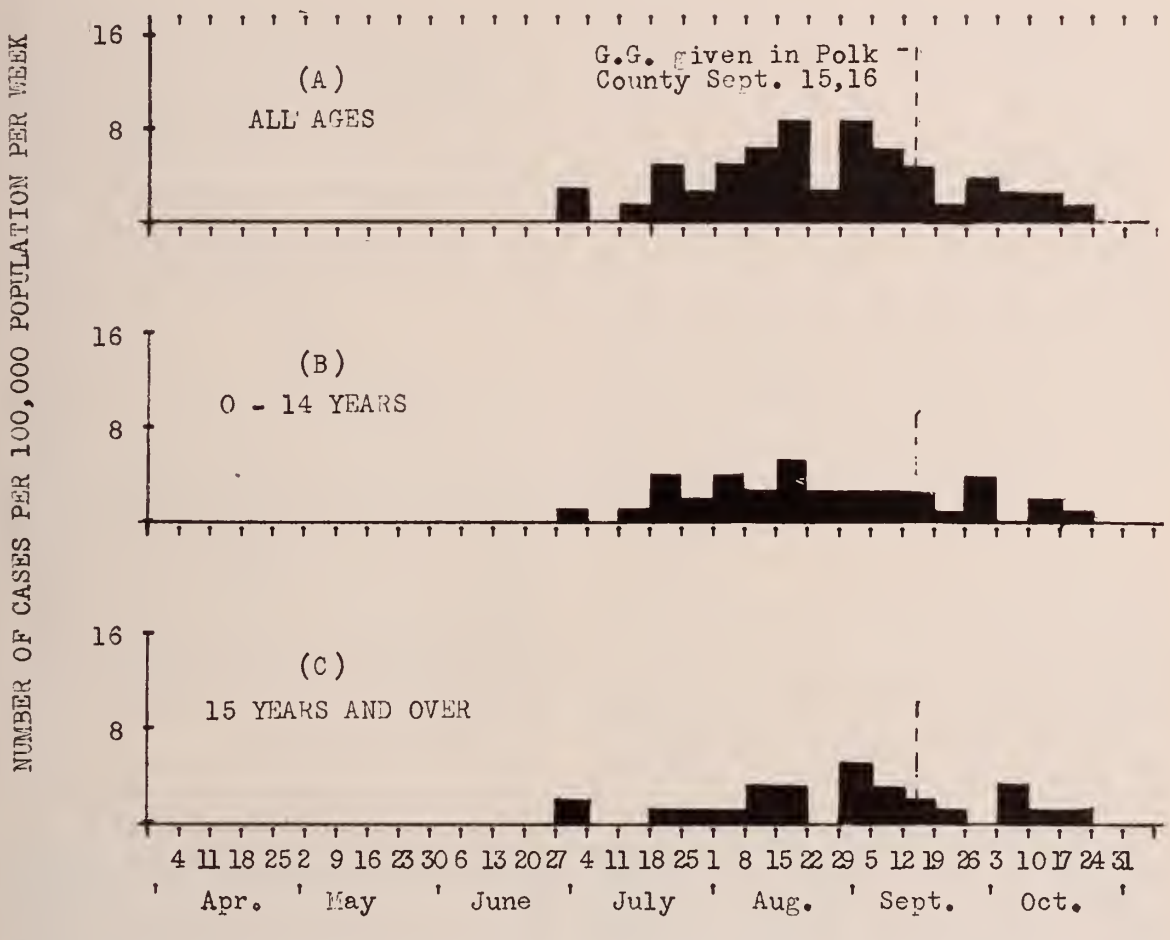
TABLE 7—*Nonparalytic Cases and Rates by Age Groups. Before and After Program*

| | Total | | Before | | After | | |
|---|---|---|---|---|---|---|---|
| | Cases | Rate | Cases | Rate | Cases | Rate | Per Cent After |
| Polk County | | | | | | | |
| All Ages | 26 | 104 | 16 | 64 | 10 | 40 | 38.5 |
| Under 15 | 16 | 218 | 12 | 163 | 4 | 55 | 25.0 |
| 15 + | 10 | 57 | 4 | 23 | 6 | 34 | 60.0 |
| Controls | | | | | | | |
| All Ages | 27 | 29 | 22 | 24 | 5 | 5 | 18.5 |
| Under 15 | 17 | 63 | 14 | 52 | 3 | 11 | 17.6 |
| 15 + | 10 | 15 | 8 | 12 | 2 | 3 | 20.0 |

Figure 4

FOUR ADJACENT COUNTIES, WISCONSIN, 1953

CASES BY AGE GROUP AND WEEK OF ONSET




from the other four counties. Reported cases are considered before and after the date of termination of the mass immunization program.

4. In Polk County, a total of 28 cases was reported in children under 15 years of age. Of these, five, or 17.9 per cent, occurred after the program in children who had received gamma globulin. In the other four counties, eight cases, or 19.5 per cent of a total of 41, were reported in the same age group, with onset after September 19. None of the latter had received gamma globulin. The difference is not significant.

5. There was a significant shift of incidence of nonparalytic cases from the lower to the higher age group in Polk County not due to gamma globulin. There is a normal change in age incidence to older age groups as poliomyelitis epidemics progress, but the high ratio of nonparalytic to paralytic cases in this group is unusual.

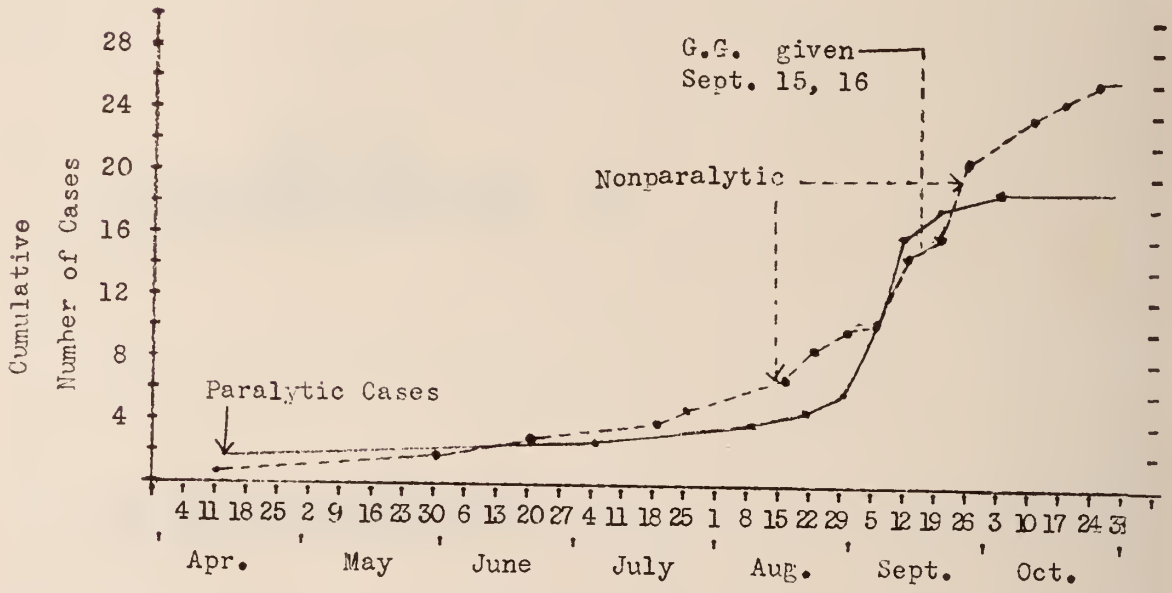
6. It is felt that psychological factors introduced by the program, combined with those already present during the epidemic, were responsible for results of a significant degree.

7. There is no evidence that gamma globulin had any effect in altering the course of the poliomyelitis outbreak or preventing cases of the disease. The small number of cases which occurred after the immunization program did not permit an evaluation of pos-

Figure 5

Poliomyelitis Polk County 1953

Paralytic and Nonparalytic Cases by Week of Onset




sible modifying effects from the gamma globulin.

8. It must be emphasized that the immunization program in Polk County, as in most counties where it was conducted throughout the United States, was instituted not at or just before the epidemic peak, but after the peak of maximum incidence. The entire evaluation of the value of mass prophylaxis in poliomyelitis by gamma globulin must be considered from this viewpoint. Perhaps, with limited supplies and the necessary administrative and organizational measures required for such programs, mass immunization programs of this type are not feasible for maximum prophylactic effectiveness. Another most important factor is the delay in reporting of cases; the physician reports to the local health officer, and he reports to the district health officer. This method is one required by statute, yet it creates a lag in establishing the time when peak incidence is approached and adds to the other factors which impair timely organization for mass immunization.

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317½ North Bridge Street.

Note 1.—The organization, administration, and conduct of the program was the responsibility of the Polk County Medical Society. It is difficult to overestimate the tremendous amount of work and time contributed by its members individually and as a group with other participating organizations. These were the National Foundation for Infantile Paralysis and its state and local branches, the Polk County Health Council, and the Polk County Public Health Nursing Service; hundreds of volunteer workers also helped. The State Department of Public Instruction contributed the services of Miss Alfaretta Wright, physical therapist, for 60- to 90-day muscle evaluation tests on all reported cases. The program was conducted in the local schools, all of which readily contributed their facilities and personnel.

Note 2—The valuable assistance of Dr. Milton Feig, Director of the Section on Preventable Diseases, Wisconsin State Board of Health, in the analysis of the epidemiological data is gratefully acknowledged.

# Hodgkin's Disease with the Primary Lesion in the Skin and Metastases to the Skull and One Rib

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## Introduction

HODGKIN'S disease may involve practically every part of the human body; skeletal metastases occur frequently, with the predilection for spine and ribs. Rarely is the skull the site of a secondary deposit; as a matter of fact, in thirty years of radiological practice, one of us (E.A.P.) has never had the opportunity of observing this. It is mainly for that reason that we report the following case.

## Case Report

X-ray No. 20109. B. T., a young married woman, now 29, originally developed skin lesions in 1947; they were a diagnostic problem for several years. Only after extensive studies in various clinics did the true nature of her illness become apparent. The skin lesions were described as macular and erythematous. They were sometimes multiple; and after October 1948, at least one lesion was present at all times. The main focus of these lesions was on the lower inner aspect of the left thigh. A diagnosis of erythema multiforme was made, and the patient was treated for this as well as for an accompanying urticaria which was believed to be due to a drug reaction. The lesions persisted and by December of 1951 were ulcerated. The first biopsy was taken from the edge of one of the ulcerated areas at that time, and a punch biopsy was done at the University of Chicago shortly thereafter. A comparison of both microscopic sections revealed a large reticulum type of cell, many with abnormal nuclei; some mitosis; and some binuclear forms. It was felt that this was a picture representing one of the lymphomas. The most likely possibility appeared to be either mycosis fungoides or Hodgkin's disease (Fig. 1). Much of the pathological material which had accumulated by January 1953 was reviewed at the Mayo Clinic, and the diagnosis was confirmed.

On February 21, 1952, the woman was referred to us for x-ray therapy to the large lesion on the left thigh (Fig. 2a). She received a total of 12 x 160 r. between February 21 and March 6, 1952, using a HVL in copper equal to .35 mm. While she was under treatment, one enlarged gland was removed from the left inguinal region; microscopic examination showed only simple hyperplasia.

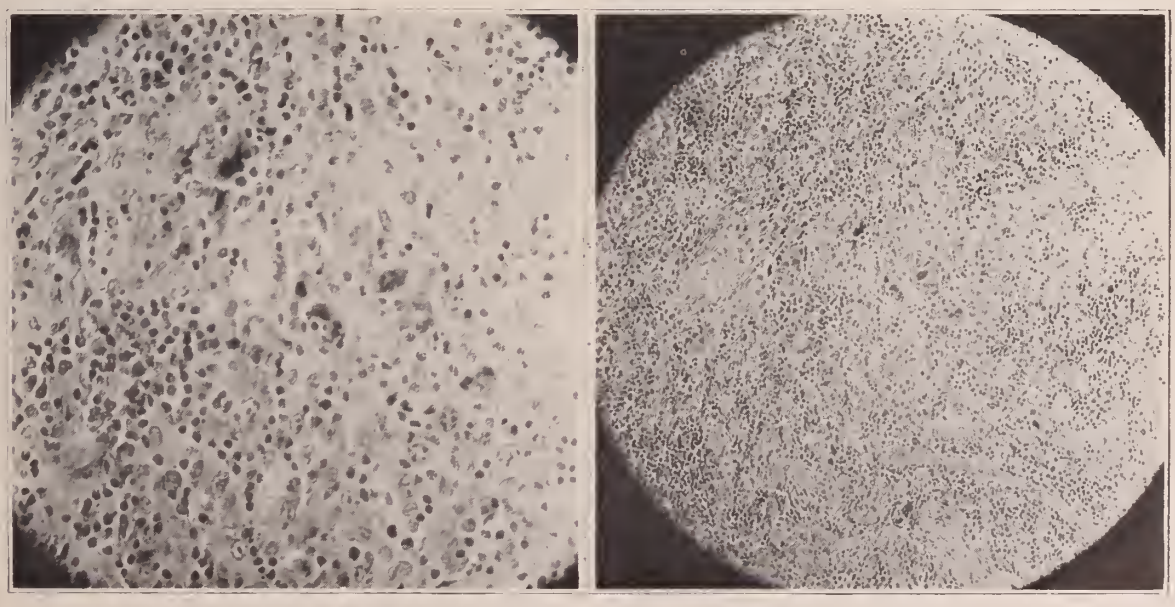

Fig. 1—Photomicrograph of section from one of the skin lesions (300X and 75X).

Fig. 2a—Lesion on left thigh before treatment.
2b—Lesion on left thigh 3 months later.
2c—Lesion on left thigh 1 year and 7 months after treatment.

By May 29, 1952, the treated lesion had healed (Fig. 2b) and remained that way as shown in a follow-up study made on September 22, 1953 (Fig. 2c). Several enlarged lymph nodes appeared during the summer in the left inguinal area, and one was removed for microscopic examination. Again the pathologist reported nonspecific lymphadenitis. A total of 2,800 r. was administered to the involved region between September 10 and 20, 1952, using heavily filtered radiation. There was good response to the treatment, and by the end of the year only one node of cherry size remained.

During May 1953 the patient complained of severe headaches; early in June a painful soft tissue swelling appeared in the right parieto-occipital region of the scalp. X-ray examination revealed an osteolytic bone lesion about 2 cm. in diameter, apparently metastatic (Fig. 3). X-ray therapy was given to the involved area; while prompt relief from pain occurred, no recalcification could be demonstrated in follow-up films taken several months later. At that time an osteolytic lesion in the right tenth rib, complicated by a pathologic fracture, was treated (Fig. 4). Again, sharp pain in that area, plus soft tissue swelling, led to its detection; the response was good. In August 1953 pelvic examination revealed the presence of a mass of about grapefruit size in the left upper pelvis; this was treated and responded well. A pelvic examination in October showed negative results. In the same month a node of walnut size in the left supraclavicular region was treated. In September, enlarged nodes in the right inguinal and right supraclavicular regions, as well as three skin lesions located in the left and right upper thigh and in the left posterior knee area, required treatment. As a supportive measure, the patient was also given nitrogen mustard at various times under the direction of the medical consultant.

## Comment

In the living patient, the bone changes of Hodgkin's disease are demonstrated on roentgenograms in about 15 per cent of the cases; 10 per cent of Dresser and Spencer's[1] cases showed ante mortem osseous changes. In Jackson and Parker's[2] series, 23 per cent showed bone lesions in life. Geschickter and Copeland[3] collected some 172 cases and found 15.7 per cent to show demonstrable skeletal changes. Vieta's[4] studies of 257 cases revealed 14.8 per cent with bone lesions. Postmortem studies reveal a markedly higher percentage of bony involvement, routinely about 50 per cent; and where careful bone surveys were done, two-thirds or more of the cases showed bony changes ranging from minute foci to macroscopic involvement.[4,5] This would indicate, then, that bone changes demonstrated by roentgenograms during life in no way reflect the true incidence of osseous involvement in Hodgkin's disease. Of course, not all lesions seen pathologically are visible on the roentgenogram. However, greater use of x-ray studies of the patient

with Hodgkin's disease will probably yield additional cases of bony involvement where none were suspected clinically. There is a tendency for the clinician to concentrate on the lymphatic system and to neglect the skeleton. The bone lesions are important clinically. It is obviously of advantage to note the extent of the involvement in a lumbar vertebra prior to, rather than after, its collapse.

Fig. 3—Roentgenogram of the skull showing osteolytic lesion in right parieto-occipital area.

It is generally believed that the main mode of spread of the disease to the bones is by the blood stream. The distribution of the lesions in the skeleton closely parallels the red marrow.[6] Jenkinson[7] states that the bones attacked by carcinoma and by Hodgkin's disease are parallel and that there is a significant similarity between the bone metastases of these two diseases. Most investigators give this order of involvement: the vertebral column, especially the lumbar area; the ribs; the pelvis; and the proximal femur. These are the areas which are rich in red marrow. Other areas of the skeleton, notably the sternum, the skull, and scapula, are involved less frequently. An occasional lesion is found in the humerus, clavicle, and tibia. The bones of the hands and feet are almost never involved.

About 10 per cent or less of the cases showing bone involvement have cranial metastases. Three of Craver and Copeland's[8] series of 27 cases showed cranial metastases. In two of these no other areas of bone involvement were observed. In Jackson and Parker's[2] autopsy series of 133 cases, no mention is made of cranial metastases other than in one case with involvement of the floor of the orbit. In Dresser and Spencer's[1] series of 66 cases, approximately nine per cent showed invasion of the skull. Vieta, Friedell, and Craver's[4] 38 cases did not include any showing involvement of the skull.

While elsewhere the most striking symptom of involvement of bone by Hodgkin's disease is pain, in the skull the presenting complaint is usually a painless swelling over the site of the bone involvement.[2] In our patient severe headaches and localized pain were the cardinal symptoms. In the skull the lesions are usually osteolytic;[8] elsewhere they may be osteolytic, osteoblastic, or both.

Fig. 4—Roentgenogram showing osteolytic lesion in right 10th rib.

On x-ray examination, the lesion or lesions are first seen in the diploë, and the radiolucent area of lytic reaction spreads to involve a relatively clear-cut circular area of bone. The scalp over the involved area presents a soft tissue mass. It is the presence of this mass which usually directs the attention of the examiner to the possibility of osseous metastases. The osteolytic areas in the skull may be surrounded by some degree of increased density, representing new bone formation. These bone changes seen in the roentgenogram are not characteristic and may be indistinguishable from the bone lesions commonly found in metastatic carcinoma. The lesions may also be confused with osteomyelitis or multiple myeloma. The diagnosis can only be established by biopsy of the

involved tissues. Response to therapy is confirmatory. In the case of lesions of the cranial vault, treatment with the use of radiation of moderate penetration is often gratifying since the lesions are superficial.

In the case reported above it is remarkable how consistent the favorable response to irradiation has remained over a period of two years.

### Summary

1. An unusual case of Hodgkin's disease is reported; the first manifestations of the disease were observed in the skin of one thigh.

2. Osseous metastatic involvement occurred first in the skull, which is rare; then it occurred in one rib.

3. The consistent favorable response to irradiation was remarkable.

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This paper was presented at the radiology section program, State Medical Society of Wisconsin, Milwaukee, October 8, 1953. Doctor Pohle is professor of radiology and Doctor Rounds is instructor in radiology at the University of Wisconsin Medical School.

# Permanent Records of the Heart Image as Seen on the Fluoroscopic Screen

By HAROLD A. BACHHUBER, M. D.
Sauk City

FLUOROSCOPY of the heart is a valuable part of the cardiac examination. Its usefulness is limited to a certain extent because of distortion of the image from magnification and because the method does not provide a permanent record. These disadvantages can be removed, we have found, by a few simple devices, which we will now describe.

As previously suggested by others, the placement of a lead ruler in the vertical cardiac plane during fluoroscopy obviates the distortion of mensuration. True heart measurements can be made from the magnified ruler.

A permanent record of the fluoroscopic image can be obtained by placing a film of .0075 special grade acetate over the fluoroscopic screen and making a tracing of this image. The calibrations of the lead ruler are traced at the same time and provide a means of obtaining accurate measurements of the heart.

The special grade acetate is a piece of translucent plastic about as heavy as an x-ray film. It can be obtained from the Transilwrap Company, 2814 West Fullerton Avenue, Chicago 47, Illinois. They will cut it to any size. The cost of the film is very reasonable.

A China marking pencil is used to make the tracing, and the lines of the tracing are later sealed by painting them with collodion.

These tracings in the anteroposterior, right anterior oblique, left anterior oblique, and any other position desired can be made very rapidly; and the measurements of heart size compare very favorably with theoretical values computed from nomograms.

It is helpful to have a set of clips on the fluoroscopic screen to hold the plastic film. Another valuable adjunct is a sixty degree angle bar for use in adjusting the patient to a sixty degree angle in the left anterior oblique position.

These fluoroscopic drawings do not require the extra equipment that orthodiascopy does, and they are easier to do and require less time than x-rays taken in similar positions.

# Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

## REPORT OF A CASE*

**Dr. Diane Croll** (Staff Physician): This patient was here two and one half years, so I really had to whittle down the history. He was a 39-year-old man who was admitted to the hospital in April of 1951 with complaints of fever, weight loss, and migrating joint pains for three and one half months. The joints involved were initially the right hip and sacroiliac joint. Later both ankles became involved, and there was a small amount of swelling. He had a past history of gonorrhea in 1937, and following this he had some joint swelling; in 1945 he began to have attacks of wheezing dyspnea on exposure to dust, and these we attributed to asthma. In 1949 he was found by his referring physician to have aortic regurgitation, and his blood pressure then was recorded as 148/60. There was no past history of syphilis, and there was no definite history of rheumatic fever. The only suggestion we had of rheumatic fever was the episode of swollen joints after he had gonorrhea.

The physical examination in April of 1951 revealed an enlarged heart, the left border extending downward and laterally to the anterior axillary line of the sixth space. The rhythm was regular; and there was a loud to-and-fro murmur over the entire precordium, the most prominent being an aortic diastolic murmur. We could not determine from the murmurs if the patient had mitral involvement or not. The blood pressure was 144/66. The laboratory tests, including blood count, urinalysis, nonprotein nitrogen, blood agglutinin, blood serology, serum proteins, Addis count, cerebrospinal fluid, blood cultures, and sternal marrow biopsy, all showed normal results. The sedimentation rate for the first year or so varied from 60 to 80 mm. in one hour. The chest film showed cardiac enlargement, with slight pulmonary congestive changes. A joint survey revealed irregular sclerotic changes involving both sacroiliac joints. The gallbladder, gastrointestinal series and colon series results were negative. The electrocardiogram initially showed a sinus rhythm, with a first degree A—V block; and biopsies of small nodules located on the arm and leg from time to time were not helpful. We really looked very hard on this man for nodules; and I think these nodules were reported as dermatofibromas, verrucae, or lesions of that nature. The patient ran a variable fever of from 100 F. to 101 F. He was given salicylates, and this produced considerable nausea and vomiting; at the same time a third degree heart block with two foci of idioventricular rhythm developed, so the drug was discontinued. Apparently he did not improve with salicylates from what I can gather from the record. Then he was tried on a course of ACTH, and this did not seem to improve his condition. Maybe some of the other doctors can tell me better; this all happened before I took care of him.

The patient had all sorts of treatments while in the hospital. He had a truss for his hernia, submucous resection for his sinusitis, and desensitizing injections for his allergy. During the next year or so, he lost weight, going from 180 to 143 pounds. He was febrile most of the time. His heart enlarged further, the point of maximum impulse being in the seventh space in the anterior axillary line. The blood pressure then showed an even wider pulse pressure, the systolic being 185 to 190 and the diastolic 50 to 60. A gallop rhythm developed. The fever persisted. The sedimentation rate remained elevated, and the patient became anemic. He had episodes of dyspnea, chest crepitations, hepatic tenderness, and ankle edema. His congestive failure varied, but we managed to control it pretty well with Digoxin. In the latter part of 1952, he began to have a few episodes of severe, oppressive precordial pain, which would come on at rest. The pain would radiate to the left arm or the neck. Sometimes it was relieved by nitroglycerin. (I am not quite sure about this).

In 1953 he definitely improved. His chest pains subsided, his failure was more easily controlled, his temperature remained normal. The hemoglobin level increased from 10.5 to

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13 Gm. The sedimentation rate gradually reduced to normal. The patient stopped losing weight. The electrocardiogram still showed a very severe first degree block with left ventricular strain pattern. At that time he used to go home on week-end passes. Except for having exertional dyspnea, he felt pretty well. In March 1953, while walking down the corridor, he again experienced severe precordial pain radiating to the shoulders and jaws, associated with sweating, and not relieved by nitroglycerin. He said these pains were pretty much like the ones he had in the latter part of 1952. The pain persisted throughout the day and was only partly relieved by morphine sulfate injection. Physical signs were unchanged. The blood pressure then was 138 60, and the patient did have some fall of systolic pressure with the precordial pain. In the evening he collapsed on the commode, became cyanotic, and expired rapidly.

In summary, we have a 39-year-old man who had a febrile illness with migrating polyarthritis and aortic regurgitation. He apparently recovered and remained compensated with digitalis and a mercurial, and then he suddenly developed precordial pain and died within 36 hours.

**Dr. Jacob N. Shanberge:** We will now see the x-rays on this patient.

**Dr. Paul Miller** (Radiology Resident): This patient had many films. Aside from the pertinent chest films, all showed negative results, with the exception of those of the sacroiliac joints, which showed some sclerotic changes. The series of chest films began with a film in April 1951. At that time the film showed cardiac enlargement, chiefly of left ventricular configuration. The lungs at the time were clear. In May 1951 there was progression of cardiac enlargement associated with pulmonary congestion. In July 1951 the congestive changes had improved, but the heart was still enlarged. Here is a film taken at the time that the cardiac fluoroscopy was done in March 1953. The left oblique film shows a greatly enlarged left ventricle. At fluoroscopy, there were noted marked systolic pulsations of the ascending aorta, with marked diastolic collapse. This is compatible with the aortic regurgitation. No calcification of any valves is noted.

**Doctor Shanberge:** Doctor Rastetter will now discuss the case.

**Dr. Joseph M. Rastetter:** (Attending Physician in Internal Medicine): I think Doctor Croll did a good job in whittling down the history. It was a very large chart. In fact, I suspect she may have whittled it a little too far and omitted some of the facts. There are some things about the history that one must take into consideration. This man was 39 years of age, and one can assume that he was in World War II and can also assume that he probably did not have valvular heart disease when he was taken into military service. However, it is well to remember that there are certain types of valvular heart disease which are quite easily overlooked. One type that is easily missed on physical examination is aortic regurgitation, especially an early one.

This man had a long period of fever, multiple joint pains, a rapid sedimentation rate, and the physical findings of aortic regurgitation. There are several diseases that one must consider, and they all fall into the group of collagen diseases—that group of diseases in which there is fibrinoid degeneration of the colloid connective tissue and matrix around the blood vessels, especially around the smaller arteries and capillaries of the body. First, I will consider lupus erythematosus. There are some things about this man's illness that suggest lupus. He had a prolonged illness over a period of at least two years, and he was a relatively young man. We know that lupus erythematosus occurs much more frequently in women, although here we see the disease occurring quite often in men. In lupus erythematosus the main changes are in the collagenous tissues of the vascular system, the serous membranes, and the synovial membranes of the body. There are also collagenous changes in the supporting matrix of the capillaries and other small blood vessels. In lupus erythematosus, there are periods of exacerbations and intermissions which go on for a number of years, usually two, three, or four. Polyarthritis is very common in lupus, as is pericarditis and often pleuritis. Usually there is depressed bone marrow function in lupus erythematosus; and there are apt to be vascular alterations in the kidneys, in the retina, and in the skin. There usually is a change in the serum proteins. The albumin drops, and the globulin rises. These patients don't have a great deal of albuminuria. They are apt to have hematuria and anemia, usually normocytic in type. It is not very often that lupus

patients present hypertension; and, as a rule, there is not a great enlargement of the spleen. They usually die of asthenia or of toxemia or some intercurrent infection. This man obviously died of a myocardial infarction. ACTH practically always produces a remission in lupus erythematosus and usually does so within 24 to 48 hours, and this patient had no response to ACTH. Mention is made of the small nodules on the arms and legs, biopsies of which were not helpful. I don't know whether it is meant that the biopsies were not helpful in prolonging the life of this individual or not helpful from a diagnostic standpoint. That statement could be interpreted in two ways.

This leads one to the consideration of periarteritis nodosa, which is another disease of the collagen group characterized mainly by prolonged fever; polyarthritis; edema; hypertension, with or without hematuria; and usually a rapid sedimentation rate. It probably represents a hypersensitivity reaction and occurs mostly in males. The fever is of a nonspecific type, somewhat like in lupus erythematosus; and at least half of the cases have a combination of fever and hypertension. Abdominal pain is very common in periarteritis nodosa, as is peripheral neuritis. This man did not have either. Eosinophilia and anemia at some time or another are commonly present.

The other disease to consider—and, of course, the most obvious one—is rheumatic fever. One may assume that the man did not have syphilis, as he did not have a positive blood serology and the spinal fluid test was negative. On the other hand, I don't know if this man received large amounts of penicillin or some other antiluetic drug; therefore, he could have had syphilis. He is in the age group where aortic regurgitation is apt to show up, although usually it comes a little later in life. He had a typical clinical picture of aortic regurgitation. The problem is, "What caused the aortic regurgitation and what eventually caused the man's death?" Rheumatic fever of the chronic type most often reveals a sedimentation rate that is not as high as in the acute form. If this man had rheumatic fever, he certainly had the chronic type. The fact that he gave no history of rheumatic fever does not mean too much. About 50 per cent of the people who have rheumatic valvular heart disease give no history of ever having had rheumatic fever in the past. In chronic rheumatic fever the sedimentation rate is between 30 and 60 mm. per hour, while in the acute form it is apt to be around 100 to 130 mm. per hour. Leukocytosis in the acute form is usually from 15,000 to 25,000 white blood cells per cubic millimeter. In the chronic form, white blood cells may be only slightly elevated or even normal in number.

There are four possibilities—chronic rheumatic fever, lupus erythematosus, periarteritis nodosa, and syphilis. This man was 39 years old. He went along for about two years with chronic heart failure. Usually that doesn't occur in syphilis with aortic regurgitation. Once the patients go into heart failure, they don't come back very well. They may have one, possibly two, and occasionally three attacks of failure; but they don't live on for two, three, or four years after heart failure occurs. In aortic regurgitation due to rheumatic fever they are more apt to have several recurrences of heart failure; and this may go on over a period of several years, especially in a man only 39 years of age. In valvular heart disease due to rheumatic fever, the mitral valve is seldom spared. After seeing the chest x-ray films and noting the dilatation of the left auricle, I wonder if the patient did not have some mitral valve involvement, possibly not heard. I think that periarteritis nodosa can be ruled out. Perhaps I should believe the doctor who wrote the history. She seems to be honest. She said the biopsies of the skin nodules were not helpful. The nodules on the arms and legs could well have been the subcutaneous nodules seen in chronic rheumatic fever. An adult with chronic rheumatic fever presenting skin nodules usually has a bad prognosis. The subcutaneous nodules indicate a rather severe form of the chronic type of rheumatic fever. I don't think the man had lues, judging from the history as given. I don't think he had periarteritis nodosa. The lack of changes in the serum proteins and the fact that he did not respond to ACTH help me to eliminate lupus erythematosus. The response to salicylates was very indefinite, but I don't know if he received adequate amounts of the drug. As long as I am confined to one or possibly two diagnoses, I should say that the man had aortic regurgitation, due to chronic rheumatic fever going on to congestive heart failure that was prolonged over a period of about a year and a half to two years. The chronic heart failure was the type from which he would recover

partially and then slip back into failure again. The cause of his death apparently was a myocardial infarction or at least severe coronary insufficiency. He probably developed this because of the narrowing of the openings of the coronary vessels. Therefore, I think the final diagnosis is chronic rheumatic fever with aortic regurgitation, possibly mitral valve involvement, and chronic congestive heart failure, with death being due to myocardial infarction and at least a severe grade of coronary insufficiency.

**Doctor Shanberge:** Is there any further comment or discussion on this case? Are there any questions anyone wishes to ask?

**Student:** Near the early course of his hospitalization, wasn't the patient thought to have had a reactivation of rheumatic fever?

**Doctor Croll:** Initially we thought he had one of the collagen diseases. Against rheumatic fever was the persistence of the illness and the failure to respond to salicylates. The allergic history favored periarteritis nodosa. However, the patient recovered so well after the second year that we thought probably he did have rheumatic fever. When he died, of course, it was a typical picture of myocardial infarction.

**Dr. Bertram H. Dessel:** That the patient did not respond to ACTH means actually that the disease did not respond. He did show an adrenal hyperactivity, didn't he?

**Doctor Croll:** Maybe some of the other doctors can answer that better than I. How about you, Doctor Sosman?

**Dr. Abe Sosman** (General Medicine): The patient had already received ACTH before I saw him, and I understand that it was discontinued because he seemed psychotic.

**Doctor Dessel:** He did make the response, though?

**Doctor Sosman:** Yes.

**Doctor Dessel:** Was his sedimentation rate dropping?

**Doctor Sosman:** Yes.

**Doctor Shanberge:** Are there any other questions? Doctor Garry?

**Dr. Mark W. Garry:** I wonder if you would tell us a little more about those nodules.

**Doctor Croll:** We really outdid ourselves on most of those nodules. Actually, they were small intradermal verrucae or fibromas which the patient had for years.

**Doctor Shanberge:** In any event, the biopsies of those nodules did not point to any specific diagnosis.

**Dr. Joseph M. Lubitz** (Pathologist): Is it not usual to have aortic regurgitation in rheumatic heart disease without evidence of stenosis?

**Doctor Rastetter:** Most cases of rheumatic fever producing chronic valvular heart disease do show a damaged mitral valve. In this case the process did involve the aortic valve and did produce aortic regurgitation. The appearance of the x-ray film showing the bulging of the left auricle into the barium-filled esophagus makes me suspicious that the patient did have some degree of mitral stenosis. I don't know what percentage of cases of rheumatic fever end up with aortic regurgitation, but I think the total is fairly high. Many cases of syphilitic aortic regurgitation die suddenly because of the coronary insufficiency due to the narrowing of the ostia of the coronary vessels as a result of the scar tissue produced by the syphilitic aortitis. In rheumatic fever, aortitis doesn't occur very often. I don't know whether or not the aortic regurgitation in this case had anything to do with producing the myocardial infarction. We do know that in a patient who has a very large hypertrophied heart, the coronary vessels do not grow in proportion to the muscle mass of the heart. There is then a disparity between the growth of the muscle mass of the heart and the blood vessels. One can assume that this man had some degree of coronary insufficiency because of the fact that he had a very large heart. It is a relative coronary insufficiency. There may be nothing intrinsically wrong with the coronary vessels. Death in this case was due to a myocardial infarction. The radiation of the substernal pain to the shoulders and the jaw, the cold sweat, and the drop in blood pressure are quite typical. The patient probably had some aortic stenosis as well as aortic regurgitation, as suggested by the to-and-fro aortic murmur. Patients with aortic stenosis are apt to die suddenly. We know that people who have congestive heart failure are apt to develop multiple emboli.

Fig. 1—Heart: Aortic and mitral valvulitis, septal infarction, and left ventricular hypertrophy.

Thrombo-embolic phenomena occur very frequently in people with heart failure. Many times they come from the legs. I should think this patient had just an ordinary myocardial infarction.

Regarding the nodules that occur in rheumatic fever, we don't see many of them in this section of the country. They do occur very commonly on the East coast and also in England. These nodules, when we do find them, are underneath the skin; they are not in the skin. From the biopsy report, I would suspect that these nodules were in the skin and properly called dermal fibromas. As one looks at the nodules and examines them, he finds that they are usually attached to the connective tissue underlying the skin. The skin is freely movable over them. They usually are found on the extensor surfaces of the joints and on the scalp. One reason we probably don't find them more often is that we don't look carefully for them.

**Doctor Shanberge:** I think that Doctor Rastetter has at least intimated in his discussion that "collagen diseases" in general simulate one another quite closely so that whether this was rheumatic fever or lupus erythematosus, we might expect many of the findings to be the same. This might also be true in other diseases such as dermatomyositis, scleroderma, periarteritis nodosa, or even rheumatoid arthritis. We found this patient interesting for one particular reason, a pathologic finding which is usually not considered to be very common by some circles, while in others it is considered quite common. In this case it was clearly demonstrated.

At necropsy this man showed no significant changes externally. His serous cavities contained a slight amount of excess fluid—approximately 200 cc. of clear fluid in each pleural cavity, about the same amount in the abdomen, and about 150 cc. in the pericardial sac. There were no adhesions of the heart to the parietal pericardium.

May we have the first slide, please? This heart was massively enlarged as you can see from the comparison of the ruler to the size of the heart. It measured 19 cm. across the base and 20 cm. from base to apex. It filled out much of the chest cavity and, even when emptied, weighed 1,000 Gm. (Fig 1). The enlargement was due to both hypertrophy and dilatation of all the chambers. The pericardial surfaces were smooth. On the right side of the heart, which we cannot see in this picture, the right atrium was massively dilated. No premortem thrombi were seen in the auricular appendage. The ring of the tricuspid valve was extremely dilated and measured 16 cm. in circumference. The right ventricle was both hypertrophied and dilated. The conus was also hypertrophied and dilated. The pulmonary valve showed no significant changes except dilatation. Though there was no old endocarditis of the tricuspid valve, it also showed a marked insufficiency due to dilatation. On the left side of the heart, the atrium was also quite dilated as well as hypertrophied. We haven't a picture of the open mitral valve, but one can see here that the chordae were markedly thickened and fused. The valve leaflets were thickened, rolled, and retracted so that there was an extreme insufficiency in the valve itself. One could insert three to four fingers through the valve orifice without difficulty. The left ventricle was both hypertrophied and dilated. The wall of the ventricle, even at the apex, measured 14 mm. in thickness and, toward the base, well over 2 cm. There was a reddish-yellow mottling of the entire septum; this extended onto the papillary muscles of the mitral valve. It involved the entire septum and extended onto the anterior and posterior walls of the left ventricle. The aortic cusps were thick and opaque. Their edges were rolled; and at the commissures the cusps were adherent for a

good distance out onto the cusp margins. There was also a dilatation of the ring of the aortic valve as well as stenosis of the valve orifice. The proximal 3 cm. of the ascending aorta presented a marked wrinkling redundancy. The next slide gives a much closer view (Fig. 2). The intima is very shiny and smooth and thrown up into the broad plaques. It is not a granular or atherosclerotic type of intima but a swollen, edematous type. The coronary orifices, as you can see, are involved in this swelling of the intima. The left coronary ostium was slightly marrowed and the right coronary ostium more so. This swelling around the right orifice, however, was of little significance since this man had a predominantly left-sided circulation. The right coronary artery gave off only a rudimentary branch to the anterior wall of the right ventricle. This swelling of the intima ceased quite abruptly, and the rest of the aorta was smooth and elastic and showed only a minimal atheromatosis. This is a very typical picture of a rheumatic aortitis. In contradistinction to syphilitic aortitis, it does not extend very far up the ascending aorta; but similar to syphilitic aortitis, it does produce a marked swelling and reduplication of the intima, so the coronary orifices are often encroached upon in both diseases.

Fig. 2—Aortic valve: Rheumatic aortitis and valvulitis

May we have the next slide, please? The microscopic characteristics of rheumatic aortitis are similar to but also different from those of syphilitic aortitis. In the adventitia, one sees infiltrations of large numbers of plasma cells as well as lymphocytes; but these seem to be centered around the nutrient blood vessels, although they may be more diffuse as in syphilitic aortitis. Here is one of the vessels, and these vessels were the same in the media and in the adventitia; this shows a perivascular fibrosis, edema and vacuolization of muscle cells, as well as swelling and proliferation of the intima (Fig. 3). Incidentally, this is not an adventitial vessel but a vessel within the media itself. In rheumatic aortitis, the lesions are very similar to the ones seen in the section of the valve that is involved in rheumatic fever; and there is increased vascularization with swelling and disruption of the collagen material. In addition, there may be infiltration of inflammatory cells; and here we do see scattered inflammatory cells throughout the area around the blood vessels.

The next slide shows a high-power view of this same vessel and pictures the marked changes occurring with extreme narrowing of the lumen of the artery. Of course, this narrowing of the lumen causes vascular embarrassment to the wall of the aorta and scars are produced. On the next slide we see more vessels with similar changes. The next slide also shows similar changes, with the perivascular infiltration of chronic inflammatory cells. There were occasional areas where one might suspect that an Aschoff nodule was present. We could not find a lesion distinct enough to call it that.

Here, on the next slide, is a section of the aorta stained with a silver stain which shows the disruption of elastic fibers (Fig. 4). In syphilitic aortitis, the destruction of elastic fibers is quite diffuse and extends through the entire media. In rheumatic aortitis, this disruption is patchy and has been spoken of as moth-eaten or flame-shaped. It is restricted more to the outer edges of the media, where there is increased vascularization. When one can see the entire vessel on section, he notices that the vessel comes in from the adventitia and extends up toward the intima but only goes about halfway through the media. Surrounding the areas of increased vascularization, one sees disruption of the elastic fibers, with swelling of the

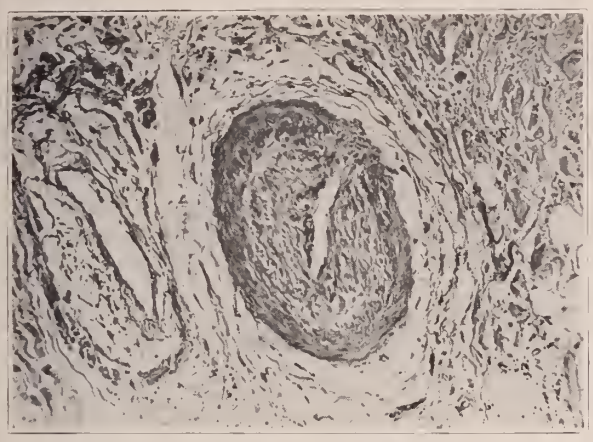

Fig. 3—Rheumatic arteritis. (249X)

collagen and then infiltration of the inflammatory cells; eventually fibrosis occurs.

The next slide shows that, in addition, there is swelling and edema of the intima. This swelling of the intima is not clearly understood because it does not seem directly due to involvement of the adventitial vessels and medial vessels but seems to occur as a reaction to something in the blood stream itself. The intima does become quite swollen, and occasionally there are distinct eosinophilic changes that occur. The entire myocardium, which was mottled, showed a very recent myocardial infarction, with dilated blood vessels, diffuse hemorrhages, and influx of numerous granulocytes. There were areas of diffuse interstitial fibrosis throughout the myocardium but no evidence of any old healed myocardial infarction. The infarction was due to a recent thrombosis of the anterior descending portion of the left coronary artery. This is significant in causing such a large infarct because the coronary circulation was predominantly left-sided. This rheumatic aortitis, according to Gross and Klinse, occurs to some extent in every case of rheumatic heart disease. The base of the aorta is probably involved whenever the myocardium or the valves are involved.

The vessel changes that one sees here are not pathognomonic of rheumatic fever. They occur in all of the collagen diseases and have been speculated to be the same type of changes which occur in malignant hypertension. The same vessel changes may occur in the smaller branches of the coronary arteries, and we did find one small arteriole in the myocardium which showed old hyalinization and narrowing very similar to these changes; but it was not a generalized feature. The man's anginal pains, which occurred for some time before the final episode, could have been due to partial occlusion of the coronary ostia by the intimal and medial edema of rheumatic aortitis. Doctor Rastetter did suggest that occasionally this occurs; but actually the intimal edema does occur more often than we do suspect, although not to the degree of causing coronary insufficiency as it did in this case. Again, it may also occur in the smaller blood vessels of the heart. Examination of the rest of the organs did not show any similar vessel changes.

This man, then, died of an acute myocardial infarction, superimposed upon a subsiding or chronic heart disease of the rheumatic fever type, with insufficiency of the mitral and tricuspid valves and insufficiency and stenosis of the aortic valve, together with a rather severe aortitis.

Fig. 4—Aorta: Rheumatic aortitis; medial "flame-shaped" scar. (240X)

## INTERNATIONAL COLLEGE OF SURGEONS TO MEET IN CHICAGO IN SEPTEMBER

The 19th Annual Congress of the United States and Canadian Sections of the International College of Surgeons will be held in Chicago, with headquarters at the Palmer House, September 7 through 10. General chairman of the Congress is Dr. Raymond McNealy, Chicago.

Features of the Congress will be general assemblies on the four mornings and afternoons; luncheon meetings each day, with the morning speakers forming a panel of discussion leaders; evening meetings including a film forum, a forum on lung cancer, the annual banquet, and the annual convocation, with Dr. Robert Johnson, President of Temple University, Philadelphia, as speaker.

# . . . . THE PRESIDENT'S PAGE . . . .

"I WILL impart a knowledge of the art to my own sons and to those of my teachers and to disciples bound by a stipulation and oath according to the law of medicine."

So spoke the immortal Hippocrates some 24 centuries ago. And from that day to this, medical men all over the world have taken pride in belonging to a profession that stated its aims, ambitions, and ideals in such a noble document as the Hippocratic oath. In the early centuries the "I will impart" had to be taken quite literally as there was no way in which a young man could join the brotherhood of physicians except through a system of preceptorial teaching. And it was not until the past few years that medical men, this time through their organizations, again began assuming some responsibility for the pledge, "I will impart," etc. I am referring, of course, to the American Medical Education Fund and more especially to the Student Loan Fund of the State Medical Society.

Now it seems to me that when a profession, acting through its organizations, demonstrates its determination to perpetuate itself on the highest possible plane by assisting its teaching institutions to continue their activities unhampered by financial embarrassment and unfettered by outside control, it thereby demonstrates its worthy position in our social system. But when physicians, again through their organizations, demonstrate their willingness to assure some young medical students that they will not have to abandon their ambition because of finances, then they have more than ever demonstrated their worthiness and their allegiance to the Hippocratic oath.

Some years ago, in a book titled, "The New Decalogue of Science," Albert Wiggam built up quite a strong case for allowing the law of the "survival of the fittest" to operate in our society. And then, to my complete satisfaction, he tore the whole argument to pieces by the simple statement that any civilization that was willing to sit by and see its weaker members go under was not a civilization worthy of survival. On that basis, then, I think we can say that we *are* worthy of survival because through the Student Loan Fund we are working against the law of the survival of the financially fittest.

No one knows exactly how many students are being financially assisted through school by older physicians, but the number is substantial. And all this without fanfare and without even the slight publicity that might attend a contribution to the Student Loan Fund. But when one sees that out of some 2,800 practicing physicians in the state, less than 50 have donated to the fund, he must conclude that the existence of the fund has been forgotten.

When one considers that if each of us donated the fee we get from three house calls a year, the fund would soon reach sizable proportions, we can realize that its actual present size is little short of tragic. It is interesting to note that one small industry in a totally unrelated field has already made a substantial contribution. If we can increase the contributions by a significant number, the trustees of the fund will have a much better case to present to potential donators in industries whose interests are allied with our own.

I appeal to you as physicians and citizens interested in the perpetuation of our profession and equal opportunity for the young people of today to take just a few minutes immediately to make your contributions to the Student Loan Fund of the State Medical Society. The fund has already made quite a number of loans, and its resources are nearly exhausted. The need is far from filled. The plight of some of the young men who have been helped was almost desperate, and I wish you could see the tremendous relief that this fund has given to such men. Your contributions are used exclusively for loans to medical students. The State Medical Society bears the cost of the administration of the fund. Let every physician make his contribution, whatever the amount may be.

H. Kent Tenney M.D.

# THE MEDICAL FORUM

## INSURANCE COMPANIES ADOPT NEW ADVERTISING CODE

THE MEDIGALS are a quartet of girl medical students at the University of Wisconsin Medical School who somehow find time for tunes as well as tasks. Snapped as they sang at the SAMA convention in Chicago were, left to right, Ellen Crabbe, Lu Ann Jones, Mary Beth Jones and Diane Dahl. (Photo courtesy of the Journal of the Student American Medical Association.)

**Read Complete Text of This Significant Public Relations Move on Page 392.**

Chicago, July 1.—Insurance companies providing policies for more than half of the 30 million Americans with individual type accident and sickness coverage have adopted a code of ethical standards for advertising.

Representatives attending the 53rd Annual Meeting of the nation's largest health insurance association—the 200-member-company Health and Accident Underwriters Conference—in New Orleans recently adopted the 14-point code of basic and special ethical standards.

The measure will cover advertising matter and descriptive literature used in newspapers, magazines, circulars, booklets, form letters and radio and TV scripts.

**"Because of the social and economic importance of this protection to the public," the Conference feels, "a serious responsibility rests with the purveyors of such insurance to hold firmly to the highest ethical and moral standards of responsible citizens of the business community."**

According to a Conference spokesman, advertising has been a big factor in the spectacular growth of the business.

The new basic standards declare that advertising must be truthful in fact and implication and not have the capacity or tendency to mislead.

**Other special ethical standards concern limitation of introductory or initial offers, use of a name or symbol akin to one popularized by hospital or medical service groups, and false claims of "no medical examination required."**

Particulars of coverage, such as dollar amounts, length of benefit duration, and age requirements are to be clearly stated for "typical" policies.

## Four More School Health Conferences Are Planned for Spring or Fall of 1955

Madison, June 9.—The unusual success of two recent school health conferences has led the Division on School Health of the Commission on State Departments to recommend four more such conferences —Stevens Point in October and Milwaukee in November of 1954, and the possibility of conferences in Superior and Whitewater in the spring or fall of 1955.

Two previous conferences held at Eau Claire and Oshkosh on April 7 and May 13 drew a total attendance of 457.

**The conferences featured addresses on the parent's concern with school health and the integrated physical and emotional growth of children. There were also workshop discussion groups with parents, school personnel, nurses and physicians taking part, on such subjects as control of disease, emotional problems of child growth, health examinations of pupils and school personnel, and health aspects of athletics.**

A meeting of the Division on School Health was attended by Dr. E. H Pawsat, Fond du Lac, chairman; Dr. W. R. Manz, Eau Claire; Dr. F. J. Mellencamp, Milwaukee; Dr. H. Kent Tenney, Madison; Dr. T. W. Tormey, Madison; Mrs. Catherine Campbell, Madison; and Mr. Orlo Miller, Madison.

Mrs. Campbell reported in detail the findings of a survey which has been conducted throughout the public school system in Wisconsin to determine prevailing school health practices. A detailed report will be prepared for the Wisconsin Medical Journal.

**The Division on School Health also made recommendations for revision of the "School Vision Screening Program" guide. Final approval of the revisions is up to the Commission on State Departments.**

It was reported at the meeting that the Wisconsin Interscholastic Athletic Association has agreed to provide a report to school officials to be sent to the family in the event of injury.

This report to the family would summarize the coverage provided by the Wisconsin Interscholastic Athletic Association and make it clear that the program is not intended as full coverage and that the physician is entitled to make an additional charge if the care so indicates.

# HANDLING MAIL, ADDRESSING, RESPONSIBLE SMS JOBS

**What does the State Medical Society do for its members? This is the eighth in a series of articles which explain the services of the society to the physicians who belong to it.**

The increase in the size of the State Medical Society's operating staff, due largely to the increase in Blue Shield sales and claims, has meant a considerable growth in mechanical problems.

It takes the entire time of two people, and occasional part-time effort on the part of others, to open, sort and distribute the incoming mail, prepare mimeographed material, and dispatch the office's daily output of outgoing mail.

**For these two staff members, the day starts with emptying the mail sacks onto a basement table. A mechanical slitter opens the letters, and each piece of mail goes through a mechanical time-stamping machine. At least 800 pieces of mail are handled each day, and a week end's mail always runs well over 1,000 pieces.**

After opening and stamping, the mail must be sorted according to department and distributed.

### Machines Used

Mechanical aids also speed the preparation of the outgoing mail. There is an addressograph machine which addresses the communications that go to all members of the society. There is a folding machine through which all sorts of bulletins and notices may be run, saving the process of folding them by hand. There is the postage meter which stamps and seals letters and produces stamped tapes to paste on large envelopes that will not go through the meter itself.

All mail must be tied up by hand into small bundles of 12 to 15 pieces before being stuffed into the mail sacks to await the pickup truck.

### Large Blue Shield Volume

In addition to the handling of mail, many mechanical jobs fall to the machine operator and her assistant.

All the PSR's (Physicians' Service Reports) from the Blue Shield office are folded and stuffed into envelopes by them.

**INCOMING AND OUTGOING MAIL is counted in the hundreds of thousands of pieces every year at the State Medical Society. It takes two full-time people and occasional part-time help to open, sort and distribute incoming mail and dispatch the office's daily output. Nearly 1,000 pieces of mail are handled every day.**

They are responsible for the large quantities of mimeographing done by the society. Often several pages are included in one item, and these must be gathered in the proper order and stapled together. When there is an extra large quantity, as there is near the time of the annual meeting, or when there is a rush job that must go out, staff members from other departments sometimes help with the gathering, stapling and stuffing operations.

The society has occasion to send out large numbers of form letters which must be more personalized than is a mimeographed letter. All new Wisconsin licentiates, for example, receive a personal letter. These are written on an automatic typewriter called a "robotype."

### Personal Service

In preparation for a robotyped letter, a roll of paper is punched on a special machine, all of the proposed letter except the salutation and address being punched. The roll is then placed on the robotype machine and "played" like the roll of an old-fashioned player piano. The operator types the address and salutation at the top of the letter, then turns on the machine which automatically writes the rest of the letter, while the operator can be doing something else.

About fifty robotype jobs are done in a typical year, with the number of letters produced by a roll varying from twelve or fifteen to several hundred.

For the sake of economy, the society buys in quantity when it purchases paper, envelopes and other supplies. This necessitates a careful inventory of thousands of items which are carefully checked off as they are used. Keeping this inventory is one of the most time-consuming tasks of the machine operator.

The addressing service of the society is of considerable value to members. The Wisconsin Medical Journal is addressed by it, and several voluntary organizations, such as the Wisconsin Anti-Tuberculosis Association pay for the service of receiving addressed labels each month for the mailing of their bulletins.

## *AMA to Discontinue Hospital Registration*

Registration of hospitals by the American Medical Association will be discontinued.

The House of Delegates acted to abolish the function of registration of hospitals by the Council on Medical Education and Hospitals of the AMA. The program of registration will be handled in the future by the Joint Commission on Accreditation of Hospitals as soon as the details of the transfer can be worked out.

# PULL TOGETHER, TIFFANY ADVISES HOSPITALS, DOCTORS

## "Stick with Insurance Principles," He Urges

Prairie du Chien, June 6.—"The practice of medicine will never again be separated from the insurance mechanism," Carl A. Tiffany, Chicago, told members of the Commission on Prepaid Plans of the State Medical Society at their recent meeting. Mr. Tiffany is consulting actuary for Wisconsin Physicians Service.

Physicians must be sure that Blue Shield continues to develop its program with full utilization of true insurance principles, Mr. Tiffany told the commission. He said that even though Blue Shield and Blue Cross have characterized themselves as prepaid plans rather than insurance plans, they utilize basic insurance principles.

**Mr. Tiffany called attention to the fact that Blue Shield and Blue Cross have been tempted to develop programs which in one sense provide a very ineffective use of the insurance mechanism. He was speaking of the provisions of Blue Shield and Blue Cross by which both plans pay for minor claims.**

### "Arm of Government"

He pointed out that it costs Blue Shield of Wisconsin about $3.00 to pay every claim, whether the claim amounts to $5.00 or $125.00. He said that Blue Shield could reduce the cost of its program by about 25 per cent if it cut out paying for items which have benefits of $35.00 or less.

He called upon hospitals and physicians to pull together in all their affairs and to recognize their common interests for their mutual protection. He said that unnecessary criticism of each other by Blue Shield and Blue Cross, doctors and hospitals, make them easy prey for those who would have the government play an increased role in health insurance.

**Mr. Tiffany warned that if either Blue Shield or Blue Cross becomes a captive of the government, both are dangerously affected. He warned that there are too many associated with the prepaid plan movement who would "just as soon be arms of the government."**

He called upon doctors to shoulder additional burdens of direction for the Blue Shield plans, to offer advice freely to patients about health insurance and medical economic problems, if they are to maintain their freedom.

The meeting chiefly involved setting up administrative details of the Blue Shield Major Illness Expense Policy, plans for which had been approved by the Council at its May meeting.

## AMA Asks Societies to Cooperate with Women's Clubs in Program Plans

Chicago, June 25.—Recognizing the important role the homemaker plays in planning for and safeguarding her family's health, the AMA has cooperated with the General Federation of Women's Clubs in working out a series of educational programs on health.

The AMA maintained an exhibit at the annual meeting of the Federation in Denver, May 31 through June 4. Distributed at this exhibit was a special kit for program chairmen entitled "Better Health—a Project for Living."

Included in this kit was a brochure called "Panacea for Program Problems," telling clubwomen how to develop programs on such subjects as overweight, medical quackery, heart disease, cost of medical care and selection of a family doctor.

**In each instance, club chairmen were advised to contact their local or state medical societies to secure a physician-speaker for the program.**

### Work Through Counties

This brochure points out the questions that should be answered in an intelligent presentation of each subject. It also lists pamphlet materials that are appropriate, and suggests background films that illustrate the point.

**County societies and auxiliaries are being contacted so that they may know that their assistance in these programs may be solicited. They are urged to bear in mind the vast possibilities for both good health education and good public relations for medicine that can result from a successful program series in each locality where one is arranged.**

## AMA PREPARES NEW EXHIBIT ON QUACKS

Chicago, June 28.—"The Modern Medicine Show" is the title of a new AMA exhibit which presents the facts on quack healers and food faddists who have duped the public into spending thousands of dollars on fake cures and devices.

First displayed at the AMA's June meeting in San Francisco, this exhibit is now available for bookings at state and county medical society meetings, state and county fairs, or other public gatherings.

**It may be obtained by writing either to the State Medical Society of Wisconsin or the AMA Bureau of Exhibits.**


**TIME IS YOUR ONLY REAL ASSET**

You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

*Disability Specialists since 1892.*

# Advertising Code for Health Insurance Will Protect Public

**The following is the complete text of the new advertising code adopted by the 200 member companies of the Health and Accident Underwriters Conference:**

More than thirty million persons are insured against the hazard of accident or sickness under policies individually underwritten. The spectacular growth of accident and sickness insurance in the past decade in some measure can be laid to the utilization of all forms of advertising by insurance companies in the distribution of their products. Because of the social and economic importance of this protection to the public, a serious responsibility rests with the purveyors of such insurance to hold firmly to the highest ethical and moral standards of responsible citizens of the business community. Accordingly, the Health and Accident Underwriters Conference, whose members provide well over half of the total volume of individual accident and health insurance, sets forth herewith Ethical Standards for Advertising Individually Underwritten Accident and Health Insurance.

### Preface

It is not intended that insurers should limit their advertising efforts or methods. It is intended that the spirit of the Ethical Standards herein set forth should control the practices in advertising not directly considered by these standards.

### Definition

Advertising is defined as including printed and published advertising matter and descriptive literature used in newspapers, magazines, circulars, booklets, form letters, radio and TV scripts.

### Basic Ethical Standards

1. Advertising must be truthful in fact and in implication.

2. Advertising should not have the capacity and the tendency to mislead those to whom the appeal is being made.

### Special Ethical Standards

1. Advertising which is likely to be seen or heard beyond the geographical limits of the insurer, as pertains to jurisdictional licensing, should indicate such limits. Direct mail insurers should indicate the base of their operations and carefully avoid implying "nation-wide" licensing.

2. Advertising should avoid the discrediting of competitors directly or indirectly.

3. No insurer's advertising of a policy or plan of insurance should tend to confuse those to whom the appeal is being made by the adoption or use of a name or symbol or both closely akin to one previously popularized by hospital or medical service associations.

4. The insurer should in all its advertising make its identity clear.

5. In advertising a particular policy or plan of insurance already in existence, expressions which imply it is an introductory offer or an initial offering to the public should be avoided.

6. In advertising a particular policy or plan of insurance, such expressions as "no medical examination required," etc., should be avoided unless no health condition is considered in underwriting or unless it is made clear that a statement of health condition is required.

7. In advertising a particular plan or policy, there should be no implication that applicants become "group" or "quasi-group" members and as such enjoy special rates or underwriting privileges, unless such is the fact.

8. When details of benefits in a particular policy or plan are set forth, the insurer should indicate in good faith the limitations, restrictions, and exclusions relative to the policy or plan. In such advertisements, the insurer shall indicate that prior origin conditions are not compensable by the advertised policy or plan unless such is a fact.

9. In advertising a particular policy or plan of insurance available to persons relatively young and relatively old alike, and/or policy or plan wherein the premium is not subject to change, the insurer should carefully avoid implying that coverage would be continuous at the discretion of the insured throughout the age spread or premium paying period described unless the policy is noncancellable and guaranteed renewable for the indicated period.

10. When advertising any policy or plan or benefits contained therein, care should be exercised to avoid implying that the policy or plan is guaranteed renewable at the discretion of the insured, unless such is the fact.

11. The advertising of particular hospital or medical policies or plans shall indicate dollar limits of benefits where applicable, and time limits of benefits where applicable, in lieu of or in conjunction with descriptive words which might imply "full coverage" for all expenses normally related to hospitalization or medical care.

12. When advertising a policy or plan of insurance, an insurer should not use testimonials, or dollar amounts of claims paid, or numbers of persons covered, or similar statistics, unless such testimonials are genuine and such statistics are accurate nor imply that such testimonials or statistics are derived from the policy or plan advertised unless such is the fact.

13. Dollar payments used in advertising to indicate the benefit payments should be typical as to benefits covered, rather than unusual.

14. Limited benefits and limited policies should not be advertised as being comprehensive.

# Doctors Invited to AMA PR Institute on September 1 and 2

Chicago, June 24.—The AMA's third Medical Public Relations Institute has been scheduled for September 1 and 2 at the Drake Hotel in Chicago.

**Designed primarily for public relations personnel and chairmen of state and county medical societies, this year's informal sessions are set up as an "idea exchange."**

One session will deal with public relations conflicts with other professions—psychologists, pharmacists, social workers, lawyers—and how to cope with them.

Another will endeavor to show how to get physicians to read society material sent to them. Still another will examine the importance of the doctors' office assistants.

Medical society sponsored television programs will be spotlighted, and there will be presentations on ways of improving AMA department services to local societies and on outstanding public relations projects of the past year.

**THE MEDICHOIR of the University of Wisconsin Medical School sang at the Fourth Annual Convention of the Student American Medical Association held recently in Chicago. The director is George Stebbins, Madison. The singers are medical students from all four classes. (Photo by courtesy of the Journal of the Student American Medical Association.)**

## COMMITTEE PAINTS GLOOMY PICTURE OF T.B. IN STATE'S MENTAL HOSPITALS

Madison, July 1.—A "dangerous" tuberculosis problem in Wisconsin's mental institutions was probed by the Division on Tuberculosis and Chest Diseases of the Commission on State Departments at its last meeting on June 16.

Physicians who discussed the matter were Doctor H. A. Anderson, chairman, Stevens Point; Einar Daniels, Milwaukee; Helen Dickie, Madison; A. A. Pleyte, Milwaukee; C. M. Yoran, Wausau; and Milton Feig, Madison. Dr. Leslie Osborn, Madison, represented the State Department of Public Welfare.

### 250 Positive

**In a majority of the county mental institutions outside Milwaukee County, little or nothing is being done about the problem of tuberculosis and proper isolation, Doctor Osborn said. They have a population of 8,770 patients.**

A survey of some 3,000 patients by the Division on Mental Hygiene of the Department of Public Welfare revealed 250 positives and 97 who were classified as being "rather dangerous" by way of contagion to other patients.

Doctor Osborn said that adequate screening; proper follow-up; adequate records; problems of isolation; and the problem of complete treatment, including psychiatric treatment during the care of the patient with tuberculosis, presented a major hurtle for the physicians of Wisconsin.

**The division reviewed the availability of facilities for handling mental defectives with tuberculosis and found that none of the existing facilities were adequate and that, at the present time, there seemed to be little likelihood of obtaining desirable facilities within the near future.**

The division is giving thought to development of a program of public and physician education to emphasize the need for intensive study of active cases, the need for treatment facilities close to psychiatric institutions and hospitals providing medical and surgical services related to tuberculosis.

County judges and medical directors of county tuberculosis sanitoria may be called upon to provide assistance.

Temporary emergency treatment facilities may be developed in or near Madison, and perhaps more adequate financial support can be given to the Douglas County Institute for the Mentally Ill so that that facility can be kept in operation until a centralized facility in or near Madison can be developed.

## All Virginia MD's Get Magazine in Campaign

Chicago, June 4.—As a special test program of the national "Today's Health" committee of the Woman's Auxiliary to the AMA, each physician and dentist in Virginia not already subscribing will receive a six-month subscription to the magazine for use in his reception room. The offer will begin with the July issue.

PBS
PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

MEMBERS OF THE COMMISSION ON PREPAID PLANS are shown during a meeting in Prairie du Chien. Left to right: Doctor Kasten, Beloit; Doctor Hill, Madison; Doctor Casper, Milwaukee; and Doctor Tenney, Madison.

## FUNDS FOR RESTORATION OF OLD FORT CRAWFORD MILITARY HOSPITAL NEEDED

Prairie du Chien, Wisconsin, June 7.—A special appeal to members of the State Medical Society to help preserve Wisconsin medical history was made at a meeting of physicians in Prairie du Chien on June 6–7.

The appeal was made in conjunction with a meeting of the medical society's Commission on Prepaid Plans, attended by about 40 physicians and guests.

Although the Commission on Prepaid Plans devotes its activities entirely to the health insurance field, the members of the Commission took time out from their proceedings to visit the Beaumont Memorial Museum and the old Fort Crawford Military Hospital. It was here that Dr. William Beaumont began studying the digestive system of a Civil War soldier, Alexis St. Martin, whose stomach was opened during a skirmish.

**During the visit to the Fort Crawford Military Hospital, Dr. W. D. Stovall, Madison, chairman of the medical society's Section on Medical History, urged all physicians in the society to contribute to a fund to transform the old military hospital into a medical museum.**

The Section on Medical History proposes that the medical museum honor Dr. William Beaumont and Dr. Walter B. Cannon, both physicians whose activities had some relation to Prairie du Chien. Dr. Cannon, a Prairie du Chien native who died in 1953, used x-rays during his World War II research which contributed to the development and use of blood plasma for shock cases.

In addition, the museum would serve as a medical shrine at which all of the contributions of Wisconsin physicians to medical science and progress could be commemorated.

**Memberships in the Section on Medical History are available at $5.00 per year. So far, about 100 physicians have joined the movement to establish the museum in Prairie du Chien. The funds will be used to restore the Fort Crawford Military Hospital and to establish appropriate exhibits and collect materials to be displayed there.**

Much of the work on the restoration of the old military hospital has already been done by a local group known as the Beaumont Memorial Foundation. The State Historical Society is also cooperating in collecting important historical documents relating to Dr. Beaumont and other persons and activities of medical significance to Wisconsin.

### HOW ABOUT YOU?

Within two weeks, Wisconsin physicians have requested more than 80,000 copies of the AMA's latest pamphlet series for use as mailing pieces or in reception rooms. If you haven't ordered your supply, do so now:

QUACK!—outlines the dangers of quack medical care.

HEALTH TODAY—the story of medical progress.

WHY WAIT?—on selecting a family physician.

ON GUARD!—how the AMA protects public health.

These four pamphlets are FREE in any quantity. Order from the State Medical Society, 704 East Gorham St., Madison.

## SMS Becomes Charter Member of Reorganized Public Health Council

Madison, June 11.—The State Medical Society has become a Charter Member of the Wisconsin Public Health Council, which voted a major reorganization at its annual meeting in Madison June 10.

The council moved to incorporate and to set up several new classifications of membership with changes in dues and voting rights.

**Under the new plan, organization membership will be by invitation only. Charter members will be major state-level professional groups and voluntary health agencies, which will pay $100 a year in dues.**

Those invited to become charter members include the Wisconsin State Dental Society, the Wisconsin State Nurses Association, the Wisconsin Hospital Association, the Catholic Hospital Association, the Wisconsin Pharmaceutical Association, the Wisconsin Association for the Disabled, the Wisconsin Anti-Tuberculosis Association, the Wisconsin Division of the American Cancer Society, the Wisconsin Heart Association, the Wisconsin Chapters of the National Foundation for Infantile Paralysis, the Wisconsin Diabetes Association, the Wisconsin Association for Mental Health, and the Wisconsin Safety Council.

Other groups will undoubtedly be invited to charter membership in the future.

**Smaller state organizations, local organizations and local councils may continue to join for $5, and individual dues have been dropped to $1 per person. In addition, provision has been made for the receipt of larger amounts of money from foundations and from industries interested in the cause of health.**

# FARMERS' WIVES STUDY, REJECT SOCIALIZED MEDICINE

(Reprinted from the **Wisconsin Agriculturist and Farmer** for May 15, 1954)

**Editor's note: After reading an article in this magazine last summer on socialized medicine, a group of farm women from the Green County Farm Bureau made an effort to learn more about socialized medicine and its benefits. Here is what they found.**

Socialized medicine has benefited some Britishers as it would in all countries that have had to turn to Socialism because of their economic conditions, but it has not done what they had hoped for or promised.

**Very few, if any, beds were added to their hospitals; fewer doctors were educated, and it has cost the British government billions of pounds which did not help the economic situation. Then they raised the costs to the individual and gave fewer benefits. It stifled initiative in the doctors and sorely overworked all, with very little compensation.**

The plan that was proposed by the Federal Administrator, Mr. Oscar Ewing, so closely resembled the British plan that over 85 per cent of our doctors disapproved it. The idea that Ewing had, that over 300,000 people were dying yearly here in the U. S., was a gross misstatement, for included in this 300,000 were traffic deaths, deaths from heart disease, cancer and old age.

A socialized form of medicine will not prevent these. To help prevent these would be education to better health. Not paying so much money out of each month's pay check and pouring it down the drain to pay salaries to the thousands of extra government employees it takes to carry on such a program.

**We enjoy better health than any country in the world, we have more doctors per capita, better educated doctors, the best trained technicians, nurses, dentists, druggists and assistants to these, more hospital beds than anywhere and it behooves us to keep it this way, not to socialize it.**

What Mr. Editor means by "time is growing short," I cannot understand. Time is growing short for what? To socialize the country more completely? The foreign countries that have gone socialistic have used socialized medicine as a wedge to gain power They print a lot of ballyhoo about people dying needlessly to stir the emotions of people, thus widening this wedge.

That we have a health problem we admit, but more progress is made where a free initiative is in power than where it is stifled by a lot of government red tape and huge debts. This idea that is prevalent in our minds today "Let the government do it" is wrong thinking. If we as individuals are not interested in our own health, we cannot expect a government that does not advocate free thinking and acting to be interested in individualism.—Mrs. Willard Murray, **Fond du Lac County.**

## PACKAGE TELEVISION SHOWS, VISUAL AIDS AVAILABLE FROM AMA

Chicago, July 1.—Two packaged television shows designed to help the medical society which has a limited television budget are now being offered by the AMA on a loan basis.

These "script clips" consist of a script which can be narrated by a local physician and an accompanying film to illustrate the script. The first of these tells the story of how vaccines are prepared and laboratory tested, how shots are given, and so on.

### Aid County Societies

The second explains how to teach a deaf child to use a hearing aid with animations showing sound waves resounding through the inner ear.

**It is hoped that county societies will find them useful, and that they will offer further suggestions to the AMA on developing more subjects.**

The AMA's Bureau of Health Education is also preparing a number of visual aids for television programs, which may be borrowed for the cost of return postage only. There are models, such as a heart or an ear; statistical charts showing average life expectancy today; and anatomical diagrams.

## Insurance Industry To Develop Long-Range Health Care Program

### Seeks Aid of Physicians

Madison, July 1.—The insurance industry is getting together for the first time to develop a permanent, long-range program to extend and improve health care and health insurance protection for the public.

A proposal is being carried out by a newly-formed Joint Committee on Health Insurance composed of prominent insurance company officers representing seven insurance associations. The chairman of the Committee is E. J. Faulkner, president of Woodmen Accident Co., Lincoln, Nebraska. Secretary is J. F. Follmann, general manager of the Bureau of Accident and Health Underwriters.

### Physicians Cooperate

Among the initial suggestions to be considered in carrying out the program are:

**1. Studies of methods to stimulate expansion of health insurance.**

**2. General recommendations dealing with health care costs, based primarily on voluntary insurance methods. This would embrace the handling of medically indigent and so-called uninsurables, with special reference to the aged; recognition of loss of income as well as direct expense as a part of health costs; and studies of the most effective balancing of insurance with other methods of meeting the different types of health costs, including self-insurance.**

**3. Improvement of services provided by insurance companies and the possibility of establishing codes of minimum insurance standards.**

**4. An effective program of public education in the use of health insurance.**

The program will be carried out through a number of task forces assigned to each of the various pending projects. Almost all insurance companies providing any types of health insurance are represented in the associations which will receive recommendations from the committee.

## *FEW HOSPITALS ELIGIBLE FOR FEDERAL AID; APPLICATION DEADLINE JULY 30*

Madison, July 1.—Only three to five Wisconsin communities will receive federal aid for hospital construction during the coming fiscal year, according to Vincent F. Otis, director of the Hospital Division of the State Board of Health.

Mr. Otis reports that federal funds are very limited, and construction costs remain high.

### Federal Rate Going Down

**Applications for federal funds for hospital building must reach the State Board of Health not later than Friday, July 30, 1954, to be considered for the fiscal year, 1954–55.**

Mr. Otis pointed out that the new rate of federal participation is 40 per cent of the allowable costs of construction. The remainder must be obtained locally by sponsors of the project.

Formerly, the Federal Government participated up to as much as 45 per cent of the cost.

**The State Board of Health is giving consideration to a recommendation by the State Advisory Hospital Council that the rate of federal participation be decreased even further to 33-1/3 per cent in the year that will start July 1, 1955.**

This would mean that projects approved during that fiscal year would also have to be under construction within the same fiscal year to obtain the rate of participation in effect at that time.

**It is important, therefore, says Mr. Otis, that communities with serious intentions to build a hospital and who wish to take advantage of the higher rate should apply this year. They must start construction before next June 30, 1955.**

### Three Top Towns

Three communities have top priority for hospital funds during the next allocation. They are Crandon, Park Falls and Chilton.

Towns having so-called second priority are Amery, Stanley, Wautoma, Eagle River, Spooner, Medford, Prairie du Chien, Black River Falls, Sparta–Tomah and Algoma.

## Subscriptions to Medical Tape-Recorded Service Will Enrich Education Foundation

Madison, June 22.—Wisconsin physicians can acquire useful knowledge and assist the American Medical Education Foundation at the same time by subscribing to the services of the Audio-Digest Foundation.

Using tape recorded material, the Foundation makes available to doctors everywhere three postgraduate services designed to save their time while increasing the scope of their knowledge. The tapes can be played on any standard tape recording machine.

**The basic service is the weekly issuance of a one-hour tape for general practitioners. On it are recorded 20 to 30 abstracts of the best in current literature embracing all medical fields. Articles are screened by a board of medical editors headed by Dr. Edward C. Rosenow, Jr., Pasadena.**

As a corollary service, Audio-Digest offers semi-monthly digests in the fields of surgery, internal medicine and OB–Gyn. The third service is lectures and panel discussions on one-hour reels for individual or group purchase. Many of these lectures are illustrated by film strips made from the speaker's own slides.

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The Foundation is non-profit—any surpluses being turned over to the American Medical Education Foundation to be used to aid financially-stricken medical schools.

The forerunner of the Foundation was a postgraduate service for California physicians offered by the California Medical Association. This service was so well received that an independent foundation was formed, and the service has been expanded to nation-wide scope.

Offices are at 800 North Glendale Avenue, Glendale, California. Mr. Jerry L. Pettis is executive director.

## *DR. EKBLAD TOLD BRITISH HEALTH SERVICES FAIL*

Superior, July 1.—A recent clipping from a London newspaper paints a rather distressing picture of health services in Britain.

**Dr. Victor E. Ekblad, Superior, received the clipping from Dr. Jim D. Hill, president of Superior State College. The clipping is reprinted in full below:**

### MENTAL PATIENTS IN CHARGE OF WARDS

**"Mental health services in one or two parts of England and Scotland had broken down and the shortage of nurses was so bad that mental patients were left in charge of wards, the Socialist Medical Association was told at its London conference yesterday by Dr. Julius Lipetz.**

### "Continuing Deterioration"

"Dr. Lipetz put a resolution—carried unanimously—on behalf of the Edinburgh and South-East Scotland branch, which said that the conference viewed 'the continuing deterioration of our mental health services with utmost concern.

### "Lamentable Failure"

**" 'The lamentable failure to provide adequate facilities for mental defectives causes suffering and mental strain in many homes,' the resolution went on. Many new hospitals were needed.**

"Dr. Lipetz said that in Edinburgh cases had to go even as far as 130 miles and there were waiting lists dating from 1951."

### 'Slum Hospitals'

"Corridors were frequently used for beds, day-rooms were used for sleeping, and beds were so close together that nurses had to pull them out to make them.

**"Dr. Horace Joules, vice-president of the association, said that 95 per cent of the hospital beds were in existence before 1914. Most could be described as slum hospitals.**

"Miss Dorothy Keeling said that in Sheffield there were 1,200 cases waiting for admission."

# Pictorial Creations of Psychiatric Patients—A Means of Diagnosis and Therapy

By HANS H. REESE, M. D.
Madison

THE picture creations of the mentally ill have become important, not so much as art objects, but more as a visual uncovering of the deep preoccupations of the mind and as a means of revealing the patients' unconscious drive towards self realization.

Psychiatry has developed many procedures for appraisal of personalities. One of the earliest was the descriptive psychiatry of Kraepelin, based upon observation of mannerisms, behavior, and the natural history of the psychoses. Later came the fundamental contributions of Sigmund Freud, with his psychoanalytic methods. While his teachings have not been universally accepted, they offer considerable help in certain types of psychiatric problems. His free association technic is a dynamic interpretation of the inner meaning of symbolization, of imagery, and of affective reactions. Recent years have seen a growth of experimental and clinical psychology to the extent where no psychiatric service is now complete without a clinical psychology department. These measures are limited somewhat by their great dependence on verbal explanations that may be fragmentary, incoherent, or displaced. It is in these circumstances that pictorial representations by the patient often reveal mental mechanisms that otherwise might be inaccessible to the examiner.

Between 1876 and 1888, Max Simon, a French psychiatrist, and Cesare Lombroso, an Italian psychiatrist and professor of criminal law, startled the medical profession when they presented spontaneous art creations of psychotic inmates and documented such perceptive productions with detailed case histories and explanations of the style, meaning, and significance of the unreal and illogical symbolization. Soon after their first publication, a large number of references to the significance of such psychotic art production followed, culminating 35 years later in the foundation of an impressive picture gallery of over 450 contributing psychotic patients.

The Psychiatric Clinic of Heidelberg under Hans Prinzhorn collected more than 5,000 pictures of esthetic quality; these are carefully recorded with clinical comparative histories.

According to Simon, the patient with schizophrenia, paranoid type, "may make pictures that are of little value from an artistic viewpoint, but are interesting for the physician and the psychologist. In these pictorial compositions the patients paint their misfortunes, the agonies they have endured and the persecutions they imagine they have been forced to experience."

Lombroso emphasized the relation of the art of the insane to the patients' personal thoughts and problems in these words: "The choice of subject is inspired by the malady and must allude to their imaginary misfortunes by means of special emblems, thus a patient with melancholia was continually carving a figure of a man with a skull in his hand, a woman affected with megalomania was always working the word Dio (God) into her embroidery, or a monomanic (paranoia) who labored under the delusion that he was being persecuted, drew his enemies pursuing him on one side of the picture and Justice defending him on the other."

These two psychiatrists, Simon and Lombroso, drew attention to the symbolic expressions of the psychotic patients, especially the intermingling of drawings and writing, now recognized as typical of schizophrenic art.

Webster defines symbolism as, "the practice or art of using symbols as by investing things with a symbolic meaning or by expressing the invisible, intangible or spiritual by means of visible or sensuous representations." The nature of the symbolic image making capacity of the unconscious, as understood in psychoanalysis, differs inasmuch as "only what is repressed from the conscious is symbolized or only the immediacies of man's personal life need to be symbolized first as visual images later to be translated into verbal rational expression under successful treatment."

The archaic style in psychotic art is a mixture of letters, hieroglyphics, and figurative signs; and it resembles the phonetico-ideographic stage of writing through which children sometimes pass and through which primitive people passed before the development of alphabetic writing.

The obscene drawings of certain psychotics aroused Simon's indignation; and since he considered them "repugnant subjects in patients violently obscene and shamelessly indecent," he "made an end of these licentious compositions." Lombroso, however, was able to accept the fact that the significance of sexual symbolism in psychotic art was in direct relationship to the conflicts. In this connection, we should recall the conventional embarrassment of the pre-Freudian period, even among physicians, when forced to deal with overt expressions of sexuality, with phallic cults, and with sexual deviates in the community, and that the interest in the studies of psychotic and primitive art had a stimulating influence upon art movements such as futurism, dadaism, and surrealism.

We must remember that only a few committed psychotics produce anything beyond occasional scribbling, paint blotching, or useless crude object copying. What, then, are the principles of interpretation and of appraising personality reactions through drawings or paintings? It is necessary to have knowledge of: 1. the theories of personality and dynamic behavior and/or deviations; 2. the progress in psychology and its newer projective technics; and 3. careful and discriminating observations, with a lifelong history of the patient's early and recent experiences and behavior; his concept of his values, aptitudes, and internal preoccupations; and the family background.

Spontaneous drawings or paintings sometimes expose the patient's repressed feelings, even though verbal explanations for his stream of thoughts, fantasies, delusions, or motivations cannot be obtained from him. This may be particularly significant in a patient whose projections are unacceptable to him as too humiliating, shameful, or blameworthy or where a mechanism of conscious or unconscious repression is utilized.

Drawing, as a motoric graphic communication, offers release and unravels conflicts in fantasy-laden subjects, in shy or inhibited children, and in mute or psychotic persons. Underlying motivations may be revealed in specific features of the drawings that express the self, the relations to reality and environment. We watch for the overdrawing of heads or genitalia and for size of elongated or distorted extremities, *i.e.* body concentration as seen in infantile types of drawing. The most common pathological expression of conflict projection is transparency of the body image or parts of it, with whirling designs alternating with extreme rigidity of posturing.

Finger painting, a creative art not allowing for too much in the way of imagination, is emotionally stimulating and permits the patient, though crudely, to express his conflicts and ideas. With this start, he may later on be induced to verbalize his symbols and projections.

Color selection identifies the emotional state. Males prefer blue and green, and for females the dominant colors are red and yellow. The choice of color depends upon the emotional conflicts and upon the meaning attached to these colors. Soft green symbolizes peace, security, rest; bright red, aggressiveness, jealousy, hate; yellow, irritability, restlessness, turmoil; and dark blue or black, depression, rejection, death. Mud is the result of mixing colors without plan or goal, is just a smearing by destructive, antagonistic, or inadequate patients. This smearing is often interspersed with thick slapping of paint, suggesting violent trends or excitable angry reactions. Picking up or effacing of color out of schemes with the hand or finger nails may be a reflection on depressive guilt conflicts. It is difficult for me to evaluate symbolization in finger painting, since I find it too abstract. Evaluating adult performances with this projection technic is hampered by insufficient verbalization, unless one can follow the patient's performance scale.

In work in the University of Wisconsin Medical School, we have utilized music and painting to understand and to help the mentally ill. Therapy schedules frequently are based on our interpretation of the patient's art productions. The interpretation of fantastic sketches or oils may reflect basic past experiences, into which ornamentation of delusional contents are scattered. These may be conventional or allegoric, religious, cosmic, human, or animal symbols. If verbal explanations or graphic descriptions accompany the pictures, as is so commonly the case, then the error of our interpretation is narrowed since the patient's meaning governs and super-

plants our consideration and ideas. Some of the sketches, especially by unskilled, poorly educated individuals, may portray bizarre, nonorganized, archaic contours and figures with primitive forms. We may see in these only indications of a psychosis; but if the patient explains that "the cow walks in the air, on the sunbeam and goes to church," or "see here, the moon makes gold, nay gold is in the sun, it is in the cross or is it hidden in the ghost," then we have a clue to symbolic inferences. Questioning about the meaning of the items in the picture may provoke incoherence and phantasy with neologisms; but in others conversation is facilitated.

Let me illustrate this point by relating a personal experience. A young man of fine physique, always shy and introspective, developed autistic trends and settled slowly into a catatonic schizophrenia necessitating commitment. In the long course of his illness he started finger painting, just disjointed smearing, up and down strokes, as if pushing thoughts away. At times he sat for hours without doing anything, evidencing no urge to create or to think. Then again he would smear mostly with brown-green smudge and then suddenly would brusquely wipe away strokes or half circles of paint in an exuberant manner. When given shock therapy, he improved somewhat and occasionally utilized his time by drawing leaves, crude trees, or what might be called fruit (an apple orchard was nearby). He finally could go out for walks alone; and every day he went to the gates of an adjacent hospital, standing for long times at the entrance and returning slowly and in a dejected mood. One day he presented the occupational therapy supervisor with a drawing of a rigid angular figure in khaki uniform, quite well executed; when praised, he smiled, but in response meticulously drew a cross over the figure's head. The symbol identification indicated that his wish to be as others—a soldier, a real man—was unattainable and had to be buried. The clue of rational insight thus given for the first time was utilized in the psychotherapy, and a fair adjustment permitted discharge with employment in a fruit storage firm. Thus, his repressed wish was early expressed by his drawings, at a time when he was verbally inaccessible. The picture he drew was simple but impressively sad and lacked the usual ornamentations of military characters, *i.e.*, helmet, gun, sidearm, and boots; and there were neither flags, cannons, nor dead enemy corpses in the dull gray background. A lonely figure symbolized the major thought content of regression without incoherency or gross phantasy.

Within certain pictures we encounter many curious forms or various body parts to the left or right of a dividing line or of a central figure, with repetitive symmetrical lateralization in rows; or we may find groups of all kinds of irrelevant additions such as faces, gargoyles, animals, birds, geometric eccentricities. They are useless for interpretation unless the patient himself elaborates on their symbolic meaning or explains them in prose or in verse.

We worked with verbally inaccessible psychotics, patients largely without cultural education who had never previously displayed artistic tendencies. This may account for the high incidence of meaningless pictures we obtained. Prinzhorn's patients, in contrast, were of a different quality. Their pictures reveal structuralized expressions of the producer's inner life. Some of them are of really high grade artistry. Even in their material, however, may be seen mystified references to demons, to the anger of gods, or to symbols of inner uncertainty.

The artistic production of the schizophrenic is too varied to permit analysis and cannot be used as a reliable bridge to his phantasy world. The splitting of the personality can develop as a feeling of alienation, of persecution, or of hypnotic influence into systematized delusions on the one hand, with the continuation of rational functions in the rest of the mind on the other. Since schizophrenics are unable to separate imagination from reality, they project their detachment from reality into unconscious misidentification expressed as perceptual experiences from outside world interferences. They see or feel them as separate pangs and may sketch or paint them as individual dissociated objects here or there, often not in their logical situation or harmonious grouping, but in a distracted perception of an assembly with unbridled accessory decorations of writing around the painting. The discrepancy of content and form manifests the symptoms of splitting from reality in its distortions, in its loosely connected symbolic imagery and its ambiguous meanings, characterizing almost a continuous ambivalent dream of surrealistic propensities with its multiple images. It is the incoherency and

the inability to concentrate, coupled with distraction by delusions or hallucinations of the mentally ill, which prevent them from thinking out organizations and reality responses. In a playful drive, the schizophrenic paints objects of his phantasy. His effort demonstrates queerness, absurdity, or nonsense. For him it is a pictorial symbolic solution, a satisfaction and a relief in his autistic thinking "to personify and to see" his enemies and "to identify" their killing and threatening influence upon him. The uneasiness, the strangeness in the composition, the *unio mystica* within his world, the supernatural tendency in the isolated objects or figures, embody schizophrenic "morbid inner processes" of an autonomous, untrained painter patient.

Written and spoken words are not the exclusive tools of communication. In psychiatry we need the verbal or written levels of expression; but if they are not available, we utilize man's creative faculties, especially those used in spontaneous drawings and paintings. By analyzing the symbolic patterns of his outward images, we gain access to the patient through these projections of his inner experiences. We value the compulsive need to release fantasies and follow the compositions until the patient is able to vocalize the symbol interpretation, even if in a disconnected, evasive, or blocking fashion. The increasing interest in using spontaneous creativity as a means of releasing and understanding the unconscious conflicts and long-buried fears is of great therapeutic value since it illustrates to us how a patient is facing and formulating, from his point of view, the realization of his divided state of mind.

The creations of Hieronymus Bosch or of Breughel the Elder are strikingly similar to those of schizophrenics, and the surrealistic symbols used by Dali embody schizophrenic-like expressions. Does a nose placed simultaneously in front or side view in a Picasso portrait intensify awareness of dimensionality or is it a mixup in vision and profile recollection? It is a legitimate endeavor of the artist to explore the esthetic possibilities of the unconscious. The similarity of their artistic productions to those of mentally ill people, especially the schizophrenics, neither depreciates abstractionism in art nor makes the creations of the psychotics equal to those of eccentric artists.


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# Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

## Treatment of Acute and Chronic Lead Poisoning

Lead is perhaps the most typical of the various cumulative poisons. Following its absorption from the digestive tract, lungs, or skin, it combines with the phosphate radical, first as a monolead phosphate; subsequently it is deposited chiefly in bone as a trilead phosphate, which is the form least soluble at the "pH" of the tissues of the body. The liver and kidneys may also contain considerable quantities of lead. In the instances of acute poisoning, the liver contains a higher concentration than the kidney, while in chronic poisoning the reverse is true.

Since certain chemical properties of lead are somewhat similar to those of calcium, the factors governing the deposition or withdrawal of calcium will very likely apply to lead. Therefore, acidosis, on the one hand, or alkalosis, on the other, may create a continued potential danger dependent upon the amounts of lead which may be mobilized from the deposits in the tissues. In the deleading process, this same principle may be employed; namely, the use of dilute hydrochloric acid, ammonium chloride, or other acidifying process to produce acidosis, or sodium bicarbonate or citrate to produce an alkalosis.

BAL (Dimercaprol, U.S.P.) has been suggested for the treatment of acute poisoning by lead; however, it appears that because of the high toxicity of this drug itself, there is but little justification for its use in these instances at the present time.

Di-sodium phosphate has been proved to be a very effective agent in the treatment of both acute and chronic lead poisoning. Judging from data obtained from experimentation on animals, it is also very effective in preventing the deposition of lead in the bones during periods of exposure to the metal. Since lead has a great affinity for the phosphate radical and combines with it to produce a reduction in its concentration in tissues, there occurs an interference with muscular contraction as a result of this deficiency of phosphate. These symptoms, however, are alleviated within a few days after the administration of this drug. The advantages of di-sodium phosphate over the other agents which also produce an alteration in acid-base balance are: 1. Mobilization and detoxification occur simultaneously; hence there is no evident danger of acute lead poisoning developing by a too rapid mobilization, as frequently occurs when other agents are employed. 2. The absorbed soluble lead, as well as that found within the intestinal tract, is rapidly detoxified by being rendered essentially insoluble. 3. An adequate amount of the phosphate radical restores to normal those muscles affected by the lead. The so-called "wrist drop" and "toe drop" may be considered to be manifestations of phosphorus deficiency, together with a consequent accumulation of lactic acid, rather than of the effect of the lead itself acting directly upon the nerves. 4. The anemia frequently observed in these cases, which is due to an increased rate of destruction of erythrocytes, is considered to be the result of withdrawal of phosphorus from the cell surfaces. Supplying an adequate amount of phosphorus usually rapidly restores the blood to normal. 5. The phosphate itself is a mild cathartic and relieves the constipation which is so commonly an early manifestation of chronic lead poisoning. Thus, the correction of this lead-induced constipation may well be due to the mild cathartic action of the phosphate itself, as well as to the detoxification of the lead, which metal has a general tonic effect on smooth muscle. 6. Since phosphates are excreted chiefly by way of the intestinal tract, the major portion of the lead, as phosphate, is also excreted by this route; and thereby the probability of renal damage is avoided.

Physicians who have employed this drug in acute and chronic cases and in instances with lead encephalopathy describe the recoveries as "dramatic." Even in the more serious instances, the patients were discharged from the hospital within a period of less

than a week. The usual recommended dosage is 1 Gm. (15 grains) daily, administered orally in four divided doses; or more may be given if the patient can tolerate it. The drug may produce nausea in some instances. In chronic lead poisoning, in which significant amounts of lead may have been deposited in the bones, treatment should be continued for a month or so to insure an adequate deleading of the patient. If this is not done, circumstances may arise which may rapidly mobilize the lead from bone in such a way as to lead to an exacerbation of the symptoms.

A new drug, the calcium salt of ethylenediaminetetracetic acid, known commercially as "Versene," "Sequestrene," or "Nullapon," shows considerable promise in the treatment of heavy metal poisoning. However, the use of this preparation in man is still so recent that very few reports have become available. Experimental data indicate, however, that it has a very low toxicity and that 95 to 99 per cent is excreted in the urine unchanged. The limited data now available on humans indicate that lead from the soft tissues is excreted very rapidly; hence the symptoms of lead intoxication disappear within a few hours. While no immediate toxic effects of this new drug were observed in the process of deleading the patients, more experience must be obtained in order to establish the overall safety of the preparation.—F. L. KOZELKA, *Professor of Clinical Pathology, University of Wisconsin Medical School.* (Introduced by A. L. TATUM, M. D.)

## ANESTHESIA AND ANALGESIA

Physicians attending births can provide valuable information by carefully recording anesthetics and analgesics that were used under Item 29 on the latest birth and fetal-death certificates. This data is being collected and tabulated at the request of the State Medical Society's Division on Maternal and Child Welfare, which is currently undertaking special studies on maternal and fetal-neonatal deaths.

One of the problems encountered has been the reporting of such non-specific items as "General," "Gas," "Routine," "Ob," or just a "√" or "X." Even worse is no entry at all—which could mean the type of anesthetic and analgesic was not indicated or that none was used.

Information gleaned from birth certificates in the past has been valuable to all practicing physicians in Wisconsin. It has broadened knowledge of problems and helped to direct effort toward improved care which has reduced maternal and infant deaths. To be of real value, information collected must be meaningful. We therefore urge all physicians attendant at deliveries to help by entering the *specific* anesthetic and analgesic or "None" if none was used.—ROBERT PURTELL, M. D., *Chairman, Division on Maternal and Child Welfare.*

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# Progress Report on Industrial Camps

## As It Looks to Your State Board of Health

EVERY summer the health needs of 12,000 or more agricultural migrant workers and their families present a challenge to local and state health agencies. The problem involves protection of the community residents as well as the migrants themselves. Reports indicate that there is considerable ill health among the migrant families, although exact information still is not available.

Many organizations, official health agencies, and the employers are now cooperating to study the needs of these workers and to make plans for meeting them. Planned health education programs, information on how to obtain medical attention, recreation programs, mothers' classes, etc., are available in some of the communities where the migrants will live for varying periods.

Adequate housing is one of the major problems and one that has been given increasing attention since minimum standards were set up over twenty years ago. The rules of the State Board of Health relating to industrial camps for migrant workers were revised and expanded in 1949. Two years later the Board was given the duty of registering and certifying such camps. An employer maintaining a camp must now register it at least 60 days before it is to be occupied. The Board inspects the camp and if minimum standards are met, issues a one-year certificate.

An increasing number of certified industrial camps and continued improvements in many of those previously registered is shown in preliminary reports of inspection for the 1954 season. A total of 53 were certified as of June 1 as compared to the same number for the entire 1953 season. Last year 333 camps were registered.

Improvements are noted in the water supply, service buildings, toilets, and general cleanliness of camp buildings and grounds.

Although encouraging progress is being made, many sanitation problems still remain to be solved by camp owners. As in previous years, the major ones continue to include unsafe well construction, insanitary privies, lack of service buildings, overcrowded sleeping quarters, improper liquid waste disposal, and inadequate screening.

In 1953 the canning industry maintained almost a third of the industrial camps in the state, containing 43 per cent of the housing capacity. These camps are larger than those in other industries and are occupied for the longest periods, varying from ten weeks to six months. This longer occupancy period seems to be an added incentive to provide good basic housing and allows canners to establish more multiple use of the housing structures. Thirty-seven of the 120 canners' camps registered in 1953 were certified. Forty-two were certified as of June 1954.

The next largest employer of migrant labor each year is the cherry industry, then the cucumber growers. Most of these camps are in Door, Waushara, and Oconto counties and last year included 199 camps, or slightly less than half of all the camps in the state. Inspections in 1953 showed sanitary conditions in the majority to be below minimum standards, and so only 14 could be certified. As of June 1, nine were certified. Camps for these industries are occupied for a shorter period of time—usually only a few weeks—as compared to time of occupancy in camps for other industries. As a result, most owners seem reluctant to invest any great amount of money in the camps.

An important characteristic of camps for the sugar beet and cucumber industries is the central operation of large groups of camps, with different growers needing laborers from year to year. For example, two sugar beet refiners operated the 39 camps in that group in 1953; and one pickle packer operated all the camps in the Oconto area for workers in the cucumber industry. None of these camps was certified in 1953. Likewise, in 1954, there will probably be none.

Sugar beet refiners, besides having the problem of handling many scattered camps from each headquarters, indicated in 1953 and previously that their financial situation was such that there was no money available for camp improvements. Another difficulty mentioned by one refiner was the increased

mechanization of sugar beet growing, which hampered planning for improvements in the camps.

Others providing camps for migrant laborers in 1953 included the logging industry; the railroads; such miscellaneous agricultural groups as growers of potatoes, onions, cranberries, cabbage, or mint; and greenhouse owners. Only one of these camps was certified in 1953; two were certified as of June 1 of this year. — HARVEY E. WIRTH, *Assistant State Sanitary Engineer.*

## SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1953, the March of Medicine began its eighth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 40 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

| *Station* | *City* | *Time* | |
|---|---|---|---|
| WATK | Antigo | Saturday | 5:15 p.m. |
| WHBY | Appleton | Saturday | 8:30 a.m. |
| WATW | Ashland | Saturday | 8:15 a.m. |
| WHSA | Brule | Saturday | 1:15 p.m. |
| WHKW | Chilton | Saturday | 1:15 p.m. |
| WHWC | Colfax | Saturday | 1:15 p.m. |
| WHAD | Delafield | Saturday | 1:15 p.m. |
| WEAU | Eau Claire | Saturday | 11:45 a.m. |
| KFIZ | Fond du Lac | Saturday | 8:30 a.m. |
| WBAY | Green Bay | Saturday | 3:15 p.m. |
| WHHI | Highland | Saturday | 1:15 p.m. |
| WJMS | Ironwood, Michigan | Saturday | 8:15 a.m. |
| WLIP | Kenosha | Saturday | 11:15 a.m. |
| WKBH | La Crosse | Saturday | 11:00 a.m. |
| WLDY | Ladysmith | Saturday | 11:00 a.m. |
| WHA | Madison | Saturday | 1:15 p.m. |
| WIBA | Madison | Saturday | 9:00 a.m. |
| WOMT | Manitowoc | Saturday | 9:15 a.m. |
| WMAM | Marinette | Saturday | 10:00 a.m. |
| WDLB | Marshfield | Saturday | 10:45 a.m. |
| WIGM | Medford | Saturday | 10:15 a.m. |
| WCAN | Milwaukee | Sunday | 6:00 p.m. |
| WEKZ | Monroe | Friday | 2:00 p.m. |
| WPFP | Park Falls | Saturday | 10:45 a.m. |
| WIBU | Poynette | Thursday | 2:45 p.m. |
| WPRE | Prairie du Chien | Saturday | 10:15 a.m. |
| WRJN | Racine | Sunday | 5:45 p.m. |
| KAAA | Red Wing, Minnesota | Monday | 9:15 a.m. |
| WRDB | Reedsburg | Monday | 4:15 p.m. |
| WOBT | Rhinelander | Saturday | 9:15 a.m. |
| WHRM | Rib Mountain | Saturday | 1:15 p.m. |
| WJMC | Rice Lake | Saturday | 10:00 a.m. |
| WRCO | Richland Center | Wednesday | 3:30 p.m. |
| WTCH | Shawano | Sunday | 6:45 p.m. |
| WHBL | Sheboygan | Tuesday | 7:15 p.m. |
| WLBL | Stevens Point | Saturday | 1:15 p.m. |
| WDOR | Sturgeon Bay | Thursday | 9:15 a.m. |
| WDSM | Superior | Saturday | 10:15 a.m. |
| WTTN | Watertown | Tuesday | 10:00 a.m. |
| WSAU | Wausau | Monday | 4:15 p.m. |
| WBKV | West Bend | Saturday | 11:00 a.m. |
| WHLA | West Salem | Saturday | 1:15 p.m. |

# THE WISCONSIN MEDICAL JOURNAL

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# « « « EDITORIAL » » »

## Medical Costs*

Much discussion of the high cost of medical care seems to assume that there has been a disproportionate inflation in the cost of a standard item. The fact is that the American people now are buying a number, variety and quality of services never before attainable.

Most sickness used to be relatively inexpensive because the usual cost was the visiting fee of the neighborhood doctor. He prescribed from his little black bag and departed, giving the patient a psychological lift and leaving him to recover if he could.

An expectant mother was on her own until the time to call in the midwife and the helpful relatives. Even infectious diseases were generally quarantined at home and a hospital was virtually notice to a patient that his condition was critical.

That stage of medical service is still available at very little increase in cost. Nowadays nobody would be satisfied with it, at least in urban communities where modern facilities are available. Thus to speak of the steep rise in the cost of being sick is like saying that it costs more to own an automobile than to walk. You also get farther, faster.

We wish that President Eisenhower had made all this a little clearer in his recent recommendations for improving the nation's health.

It needs to be emphasized that the problem is less to reduce medical costs than to enable more people to obtain the marvelous new services developed by the medical and allied professions.

For the man of modest means, serious illness in the family is a financial misfortune. Millions of Americans protect themselves to some extent by hospital insurance. It might be better, however, if rather than insuring himself against ordinary costs, he paid his premiums for protection against calamitous bills, much as he buys $50 deductible automobile insurance.

In view of the progress made in the United States toward better health, it is a distortion to speak of improving it as if it were a neglected problem.

Mr. Eisenhower's proposals for revising federal assistance in the construction of hospitals meet a particular need. Such facilities are distributed very unevenly in the country. When backward states are doing their utmost, it is reasonable to extend some help.

* Editorial reprinted from February 4, 1954, *Chicago Daily News*.

Another profitable job for the federal government is the sort of research leadership provided by the Public Health Service. State and federal programs for rehabilitating the disabled, and for aiding the chronically ill, are of long standing. As the national means permit, their expansion is in order. The President was at his best in pointing out the returns to the community, as well as to the individual, in helping the disabled to lead normal lives.

What needs to be realized is that it is not politics, but science plus constant growth in national wealth that will bring progress about.

## "The Razor's Edge"—or Who's Cutting Whom*

The Wisconsin Medical Journal for last July carried an editorial which has tickled the pens of several fellow editors. Its author had arrived at the barber shop during the rush hour on Saturday. No social solvent, such as alcohol, is necessary to unleash the tongues in barber and beauty shops. We know about barber shops; the women bring home a few pearls from the others. Trade schools might do well to add some lectures on ethics in their curricula.

"Many a truth is said in jest," and a contemporary bard has said that we are what people say we are—behind our backs. Thus, our colleague picked up a few points in the barber shop. More than ever he realized that patients are often a lot wiser than we might suspect; and usually they know more about doctors in general, and the physicians of their choice in particular, than we think. In this instance, some of our faults were aired, and the doctor saw himself as others see us:

Unfortunately too many people think all doctors charge too much. For those who receive unitemized bills "For professional services rendered" which seem unreasonably high, and then see too much evidence of affluence among medical men and their families, their impressions seem to be confirmed. When a layman has tried unsuccessfully to procure medical services at night, he is apt to be embittered. If he waited two or three hours the last time he went to his doctor's office, he resented it. His time is valuable, too.

A few patients figure that some doctors boost the ante when health insurance forms are presented to be filled out. No wonder, in his mind, that premiums have gone up. These things invite socialized medicine. How about "smart-alecky" office girls who ask too many personal questions, and sometimes before other people? But more important, what about the physician who seems to be devoid of sympathy? A smile and some explanation about what's wrong and what is the best thing to do about it might do a lot more good than a shot of penicillin, and it would be a darn sight cheaper! And how much is it going to cost, Doc? "Don't worry about that," he says. Suppose you gotta worry about it? Furthermore, how come so many doctors slam each other? That doesn't sound like much of a man, especially a professional man, and it beats down a fellow's confidence in all of them.

There you have it, men—right straight from the barber shop. What would the barber have said, had he known his next patron was a surgeon? He'd probably have been so nervous that somebody's life would have been in danger. Not only that but it might dawn on the barber that he is a man of great responsibility, standing there with a razor in his hand. Maybe he'd better double the price of a shave, especially if his patron survives!

* Editorial reprinted from February 1954 *Rocky Mountain Medical Journal.*

## POLIO VACCINE TRIAL NEEDS PHYSICIANS' AID AS IT MOVES INTO EVALUATION PHASE

More than 600,000 children have completed three inoculations in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The emphasis now shifts to the evaluation study under the direction of Dr. Thomas Francis, Jr., University of Michigan School of Public Health. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, *including those children in the first three grades who did not get vaccine.*

In addition, data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that all cases are completely reported. Early diagnosis, prompt reporting and follow-up, and the securing of *necessary epidemiological information and laboratory specimens* are important factors in the evaluation.

An outline of procedures and copies of necessary forms have been sent to local and state health authorities. It is important that physicians in areas where vaccinations were not given cooperate in the study by notifying local or state health officers of cases occurring among children who participated in the trials and then migrated to another area and children who go to summer camps. Local health officials also need information on participating children who receive injections of gamma globulin.

This phase of the study will depend, to a large degree, on the wholehearted cooperation of practicing physicians.

# Annual Meeting

# ANNOUNCEMENTS

**DATES: October 4–5–6, 1954—Milwaukee Auditorium and Hotel Schroeder**

*House of Delegates:*
- MONDAY, OCT. 4: 9:00 a. m.
- TUESDAY, OCT. 5: 7:30 p. m.
- WEDNESDAY, OCT. 6: 8:30 a. m.

*Golf Tournament:* MONDAY, OCT. 4: Ozaukee Country Club. Tee off at 10:00 a. m. Reservations through A. H. Luthmers, Room 700, 208 East Wisconsin Avenue, Milwaukee 2. $9.00 per person, including dinner, green fees, prizes, and entertainment.

## *Scientific Program Features:*

TEACHING DEMONSTRATIONS:
- MONDAY, OCT. 4: 10:00–11:00 a. m., 3:00–3:45 p. m.
- TUESDAY, OCT. 5: 9:00–10:00 a. m., 3:00–3:45 p. m.
- WEDNESDAY, OCT. 6: 9:00–10:00 a. m.

1. **Postanesthesia Recovery Room:** Wisconsin Society of Anesthesiologists; James W. Bookhamer, M. D., Milwaukee, and associates.
2. **Meeting the Needs of the Amputee:** Ray Piaskoski, M. D., and associates, VA Medical Center, Wood
3. **The Cranial Cavity (Dissections):** Anatomy Dept., University of Wisconsin Medical School, F. D. Geist, M. D., and P. H. Settlage, M. D.
4. **OB Manikin Demonstrations (Through Wisconsin Society of Obstetrics and Gynecology)**
   - Monday, Oct. 4: "Version Extraction and External Version": L. T. Servis, M.D., Milwaukee
     "Management of Transverse Presentation and Breech Presentation": Elizabeth A. Steffen, M. D., Racine
   - Tuesday, Oct. 5: "Version Extraction and External Version": David J. Werner, M. D., Milwaukee
     "Management of Transverse Presentation and Breech Presentation": S. D. Austin, M. D., Green Bay
   - Wednesday, Oct. 6: "Manual and Forceps Rotation of the Occiput Transverse and Occiput Posterior Presentations and Positions": Russell Lewis, M. D., Marshfield
5. **Gross Tissue:** Display and discussion by members of the Wisconsin Society of Pathologists.

SPECIAL INTEREST PROGRAMS:

**Tuesday, Oct. 5:**
- PEDIATRICS: Robert Lawson, Miami, Florida; Albert Schroeder, Minneapolis
- INTERNAL MEDICINE: Hans Selye, Montreal, Canada; William Bean, Iowa City
- RADIOLOGY: David Pugh, Rochester, Minnesota
- ORTHOPEDICS: Paul Williams, Dallas, Texas; W. Brandon Macomber, Albany, New York

**Wednesday, Oct. 6:**
- OBSTETRICS AND GYNECOLOGY: Howard Tatum, New Orleans; John Brewer, Chicago
- CARDIAC AND PULMONARY DISEASES: Charles Cameron, New York; Thomas O'Neill, Philadelphia
- SURGERY: Henry Doubilet, New York; William Grove, Chicago
- OPHTHALMOLOGY AND OTOLARYNGOLOGY: Justin Donegan, Chicago; George Baker, Rochester, Minnesota; Meyer Fox and John Hitz, Milwaukee
- PATHOLOGY: George Haas, Chicago

# Scientific Exhibits—

Through the cooperation of the physicians and agencies listed below, an exceptional display of scientific exhibits will be provided as teaching material for the 1954 Annual Meeting. Some will be housed in the north center part of Bruce Hall, in the Milwaukee Auditorium, which will also house the commercial exhibits and the teaching demonstrations. Other exhibits will be located in the foyer outside of Juneau Hall and in the back half of Juneau Hall. Listed below are the agencies and physicians participating:

## EXHIBITS IN JUNEAU HALL AND ADJOINING FOYER:

American Cancer Society (Milwaukee and Wisconsin Divisions): A full schedule of professional movies on various subjects related to cancer and a special exhibit on **"Lung Cancer"**

Department of Surgery, Marquette University: **"Vascular Surgery and the Use of the Artery Bank"**

Columbia Hospital, Milwaukee: **"Non-Tuberculous Acid-Fast Bacillus Infections of the Lung"**: Dann B. Claudon, M. D.; **"Plethysmography in Vascular Diseases"**: James E. Conley, M. D.; **"Cyclic Changes in Cervical Mucus"**: Benjamin E. Urdan, M. D., Alvin M. Kurzon, M. D.; **"Anticoagulant Therapy"**: John O. Chamberlain, M. D., Fred W. Madison, M. D.; **"Porphyrinuria in Lead Poisoning"**: Elston L. Belknap, M. D., Margaret C. Perry, M. A.; **"Paper Electrophoresis"**—Robert R. Koenig, M. D., Benedict M. Polcyn, M. D., Gorton Ritchie, M. D.

VA Medical Center, Wood

Wisconsin Anti-Tuberculosis Association: **"Minifilms May Suggest Pulmonary Diseases"**

Milwaukee Children's Hospital and Marquette University: **"Epilepsy"**

University of Wisconsin Medical School: **"Pathology of Bronchial Asthma"**: S. B. Crepea, M. D.; **"Diagnostic Aids in Congenital and Acquired Heart Disease"**: Charles Crumpton, M. D.

State Laboratory of Hygiene: **"Services of the State Laboratory Available to Physicians"**

VA Hospital, Madison: **"Pulmonary Function"** and **"Anesthesia Related to Pulmonary Disease"**

Henry Suckle, M. D., Madison: **"Hydrocephalus"**

## EXHIBITS LOCATED IN BRUCE HALL:

Raymond Rice, M. D., Milwaukee: **"Practical Ballistocardiography"**

Leon Unger, M. D., Chicago: **"Respiratory Allergies in the Farm Population"**

E. P. Roemer, M. D., Madison: **"A Positive Program for the Management of the Multiple Sclerotic"**

A. L. Rhoades, M. D., Jackson Clinic, Madison: **"The Tearing Eye"**

Motor Vehicle Department: **"The Drunkometer and Highway Safety"**

American Medical Association: **"Mechanical Quackery"**; **"Testing the Drinking Driver"**; **"Physicians' Responsibility in Highway Accidents"**; **"Etiology of Malpractice"**

Wisconsin Academy of General Practice

Section on Radiology: Selected exhibits of radiologists of special interest to general practitioners.

# DISTINGUISHED GUEST SPEAKERS

JOHN ADRIANI, M. D.
Professor of Surgery, Tulane University School of Medicine, New Orleans

LEO H. BARTEMEIER, M. D.
Associate Professor of Psychiatry, Wayne University, Detroit, Michigan

GEORGE S. BAKER, M. D.
Assistant Professor of Neurosurgery, Mayo Foundation Graduate School, Univ. of Minnesota

*Special Feature . . .*

Each day a full schedule of round table discussions will be presented on a variety of scientific subjects. Attendance at each is limited, and you are urged to make your reservations immediately! See pages 411 and 412 for the topics and leaders, and page 402 for the reservation blank to be used.

JOHN I. BREWER, M. D.
Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago

HENRY DOUBILET, M. D.
Associate Professor of Surgery, College of Medicine, New York University, New York City

ALBERT FAULCONER, M. D.
Head of the Section of Anesthesiology, Mayo Clinic, Rochester, Minnesota

# DISTINGUISHED GUEST SPEAKERS

WILLIAM J. GROVE, M. D.
Associate Professor of Surgery, University of Illinois College of Medicine, Chicago

ROBERT B. LAWSON, M. D.
Chairman, Department of Pediatrics, University of Miami School of Medicine, Miami, Florida

W. BRANDON MACOMBER, M. D.
Associate Professor of Plastic and Reconstructive Surg., Albany Med. College, Albany, New York

*Special Feature . . .*

Be sure to attend the Annual Dinner, as the *final event* of the Annual Meeting. No long speeches, no "heavy" oratory! Music, professional entertainment, and dancing for those who wish to do so. Following the floor show there will be dancing until midnight. Attendance limited, so order your tickets now. See page 402 for the reservation blank to use.

DAVID G. PUGH, M. D.
Assistant Professor of Radiology, Mayo Foundation Graduate School, University of Minnesota

HANS SELYE, M. D.
Professor and Director, Institute of Exp. Medicine and Surgery, University of Montreal, Canada

HOWARD J. TATUM, M. D.
Associate Professor of Obstetrics and Gynecology, Louisiana State Univ. Med. School, New Orleans

PAUL C. WILLIAMS, M. D.
Clinical Associate Professor of Orthopedic Surgery, Southwestern Medical School of the University of Texas, Dallas, Texas

## *Guest Speakers Not Pictured . . .*

WILLIAM B. BEAN, M. D.: Professor of Internal Medicine, State University College of Medicine, Iowa City

CHARLES S. CAMERON, M. D.: Medical Director, American Cancer Society, New York City

JUSTIN M. DONEGAN, M. D.: Rush Associate Professor of Ophthalmology, University of Illinois College of Medicine, Chicago

FRED W. FITZ, M. D.: Chicago

GEORGE M. HASS, M. D.: Rush Professor of Pathology, University of Illinois College of Medicine, Chicago

THOMAS O'NEILL, M. D.: Philadelphia

ALBERT SCHROEDER, M. D.: Clinical Instructor in Pediatrics, University of Minnesota Medical School

## ROUND TABLE LUNCHEONS

*Note:* Listed below and on the following page are the scientific luncheons, attendance at which is strictly limited. To avoid loss of time in correspondence, kindly fill out the reservation blank on page 402 with a listing of three choices, in order of preference, for each of the days you will attend.

Also include with your reservation your request for dinner tickets. Attendance at this function is also limited.

## *Monday, October 4*

1. LEO H. BARTEMEIER, M. D., Detroit: "Everyday Emotional Problems in Medical Practice"
2. EINAR R. DANIELS, M. D., Milwaukee: "Early Manifestations of Pulmonary Disease"
3. CARL W. EBERBACH, M. D., Milwaukee: "Hyperthyroidism: The Rationale of Modern Treatment"
4. W. S. MIDDLETON, M. D., Madison: "Newer Drugs and Their Uses"
5. JOHN C. PETERSON, M. D., Milwaukee: "General Principles of Fluid and Electrolyte Therapy in Infants and Children"
6. HERBERT W. POHLE, M. D., Milwaukee: "The Management of Hypertension"
7. GEORGE L. THOMAS, M. D., Janesville: "Fractures of the Os Calcis"
8. HERMAN H. SHAPIRO, M. D., Madison: "Home Management of Congestive Heart Failure"
9. W. D. STOVALL, M. D., Madison: "Viruses in Wisconsin: Their Recognition and Control by Immunization"

### *Special Luncheon*

10. PAST PRESIDENTS' LUNCHEON:
All past presidents of the State Medical Society, the current president, and the current president-elect are to attend this luncheon.

# Tuesday, October 5

1. JOHN ADRIANI, M. D., New Orleans: "Obstetrical Anesthesia and Analgesia"
2. WILLIAM B. BEAN, M. D., Iowa City: "Clinical Vagaries of Myocardial Infarction"
3. HARRY BECKMAN, M. D., Milwaukee: "Recent Pharmacologic Developments of Clinical Interest"
4. CHARLES W. CRUMPTON, M. D., Madison: "Clinical Evaluation and Medical Treatment of the Hypertensive Patient"
5. ALBERT FAULCONER, M. D., Rochester, Minnesota: "What Is the Meaning of 'Depth of Anesthesia'?"
6. FRED W. FITZ, M. D., Chicago: "Bedside Diagnosis and Treatment of Cardiac Arrhythmia"
7. ROBERT B. LAWSON, M. D., Miami, Florida: "Antibiotic Therapy in Pediatric Practice"
8. W. BRANDON MACOMBER, M. D., Albany, New York: "The Treatment of Lower Leg Soft Tissue Deformities"
9. ALBERT J. SCHROEDER, M. D., Minneapolis: "Erythroblastosis"
10. DAVID G. PUGH, M. D., Rochester, Minnesota: "Osteomalacia and Osteoporosis"
11. JAMES C. SARGENT, M. D., Milwaukee: "Prostatism in Elderly Men"
12. HANS SELYE, M. D., Montreal, Canada: "The Use and Abuse of Cortisone and Allied Hormones in Clinical Medicine"
13. PAUL C. WILLIAMS, M. D., Dallas, Texas: "Choosing the Candidate for Lumbosacral Surgery"

## Special Luncheon

Marquette Alumni Luncheon: Blatz Auditorium. (Do not make reservations for this luncheon through the State Medical Society but rather by writing Mr. Ray Pfau at the Marquette Alumni Association office, 1533 W. Wisconsin Avenue, or by phoning Mr. Pfau through Division 4–1000, Milwaukee)

# Wednesday, October 6

1. JOHN I. BREWER, M. D., Chicago: "Abnormalities of Menstruation"
2. HENRY DOUBILET, M. D., New York: "Status of Emergency Operation on the Acute Abdomen"
3. CHARLES S. CAMERON, M. D., New York: "To Tell or Not to Tell" (The Cancer Patient)
4. WILLIAM J. GROVE, M. D., Chicago: "The Direct Surgery of Arteriosclerosis with Particular Reference to Abdominal Aortic Aneurysms"
5. OVID O. MEYER, M. D., Madison: "Newer Drugs and Their Uses"
6. FRANCIS D. MURPHY, M. D., Milwaukee: "Cardiac Emergencies"
7. HOWARD J. TATUM, M. D., New Orleans: "Pregnancy Complicated by Heart Disease"
8. DONALD M. WILLSON, M. D., Milwaukee: "Benefits and Hazards from the Administration of Potassium Salts"

## Special Luncheons

9. Public Health: "Viral Hepatitis" with NED G. MAXWELL, M. D., Milwaukee, as discussion leader
10. Pathologists: GEORGE M. HASS, M. D., Chicago: "Present Status of Human and Experimental Studies on the Pathogenesis of Arteriosclerosis" (Followed by meeting of Wisconsin Society of Pathologists)
11. Section on Ophthalmology and Otolaryngology: Luncheon, followed by scientific program in same room. Speakers: JUSTIN DONEGAN, M. D., Chicago; GEORGE BAKER, M. D., Rochester, Minnesota; and DRS. MEYER FOX and JOHN HITZ, Milwaukee

Use Reservation Blank on Page 402

**NAME 3 CHOICES FOR EACH DAY YOU WILL ATTEND**

# Minutes of the Council Meeting, Milwaukee, February 27 and 28, 1954

### 1. Call to Order

The Council was called to order by Chairman Arveson at 3:45 p.m., Saturday, February 27, at the Milwaukee Athletic Club, Milwaukee.

### 2. Roll Call

Councilors present were Doctors Costello, Hemmingsen, Kasten, Dessloch, Heidner, McCarey, Fox, Bell, Garrison, Arveson, Ekblad, Galasinski, Casper, Wegmann, Zellmer, and Past-President Griffith.

Also present were President Tenney; Treasurer Weston; Speaker Simenstad; Vice-Speaker Fons; Dr. D. H. Witte, delegate to the American Medical Association; Dr. C. N. Neupert, state health officer; and Dr. J. M. Sullivan, chairman of the Committee on Public Policy (Sunday only).

Staff members present were C. H. Crownhart, secretary; Robert B. Murphy, legal counsel; Roy T. Ragatz, assistant secretary; Earl R. Thayer, director of public information; and Miss Jean McGruer of the Society's office.

### 3. Approval of Minutes

On motion of Doctors Zellmer–Hemmingsen, carried, the minutes of the November 1953 meeting as published in the December 1953 issue of *The Wisconsin Medical Journal* were approved.

### 4. Budget for 1954

The secretary briefly reviewed his report and recommendations as to the budget and pointed out some items in particular; for example, that the budget contemplates the addition sometime during the year of a business manager to the Society staff. The recommendation is based on the belief that with the expenditures involved and the complexities of Society affairs, the employment of one individual to watch costs and handle management of the new building and all purchasing would ultimately, at least, save for the Society the amount of salary required.

The secretary also reported an increase in *Wisconsin Medical Journal* printing rates, which has necessitated some changes to cut down on costs. The "Journal red" has been changed to conform with the red in certain advertising, thus obviating the necessity of two separate "color runs." The secretary stated further that unless he had instructions to the contrary, the staff would attempt to make arrangements with the *Milwaukee Medical Times* so that its advertising solicitor might have an opportunity to solicit advertising for *The Wisconsin Medical Journal.*

In addition to reporting on the 1954 budget, which was approved by the Audit and Budget Committee for submission to the Council, Mr. Crownhart reported for the committee that it had approved a retirement plan for Society employees, pursuant to authority delegated it at the time of the October 4, 1953, meeting of the Council. Under this plan the members of the Audit and Budget Committee constitute the trustees of the funds segregated for retirement purposes. The committee has designated the secretary of the Society as the secretary for the trustees, and the signatures of both the chairman and the secretary will be required for the withdrawal of funds. The committee has approved submission of the program to the Bureau of Internal Revenue for its approval.

In view of the responsibilities of the trustees under the retirement program and the desirability that there be continuity in office, the Audit and Budget Committee recommended to the Council that henceforth appointments to the committee be for a term of three years and that, by lot, committee members determine expiration of appointments, one in 1955, two in 1956, and two in 1957.

> On motion of Doctors Zellmer–Griffith, carried, the Council acted to approve three-year appointments for Audit and Budget Committee members.

Finally, Mr. Crownhart spoke of the increasing demand upon the Medical Society and its staff in developing and working on programs and projects directed by the many committees. He recommended closer liaison between the Council, the reference committees of the House of Delegates, and Society committees that are carrying on the programs in order to keep abreast of these programs and of the costs involved.

The budget, as reviewed item by item and approved by the Council for the year 1954, follows:

| *Account* | *Budget Item* | *Appropriation* |
|---|---|---|
| 53 | CENTRAL OFFICE NORMAL OPERATING EXPENSE | |
| 531 | President's Travel | $ 750 |
| 532 | Council, Officers, Delegates, and Committee Meeting Expense | 13,000 |
| 533 | Association and Dues Expense, State and National Organizations | 800 |
| 534 | Resource and Informational Material | 750 |
| 535 | Woman's Auxiliary to the State Medical Society | 1,200 |
| 536 | Accounting and Insurance | 2,000 |
| 537 | Rent — *1954 Monthly Rates* | 7,680 |
| | State Medical Society $640.00 | |
| | Veterans Agency 195.00 | |
| | Wisconsin Physicians Service 907.50 | |
| | Wisconsin Medical Journal 40.00 | |

| Account | Budget Item | Appropriation |
|---|---|---|
| 538 | Telephone and Telegraph | $ 2,000 |
| 539 | Office Supplies | 5,000 |
| 5310 | Postage, Printing, and Stationery | 5,500 |
| 5311 | Upkeep and Fixtures | 800 |
| 5312 | New Equipment | 1,000 |
| 5318 | Legal | 3,600 |
| 5319 | Bulletins on A.M.A. Meetings | 600 |
| 5320 | Blue Book Issue, Special Appropriation | 2,500 |
| 5325 | Miscellaneous | 1,000 |
| 54 | PUBLIC HEALTH INFORMATION, SPECIAL ACTIVITY | |
| 541 | *Today's Health* | 490 |
| 542 | Lay Publications | 300 |
| 543 | Special Bulletins | 500 |
| 544 | Wisconsin Medical Journal Special Inserts | 500 |
| 545 | Special Telephone and Telegraph | 350 |
| 546 | Legislative Counsel | 3,600 |
| 547 | Miscellaneous | —— |
| 55 | PUBLIC HEALTH INFORMATION, PRESS AND RADIO | |
| 551 | Press Releases | 400 |
| 552 | Health Conferences, Exhibits, and Publications | 1,000 |
| 5530 | March of Medicine, Recording | 800 |
| 5531 | March of Medicine, Supplies | 300 |
| 5532 | March of Medicine, Printing and Postage | 500 |
| 5533 | March of Medicine, Television | 3,000 |
| 554 | Miscellaneous | 300 |
| 56 | MEDICAL SERVICE, OPEN PANELS | |
| 561 | Applications and Correspondence | —— |
| 562 | Panel Printing | 1,000 |
| 563 | Envelopes | —— |
| 564 | Postage and Addressing Costs | —— |
| 565 | Miscellaneous Expense | —— |
| 57 | ANNUAL MEETING | 1,000 |
| 58 | TEACHING CLINICS, INDUSTRIAL HEALTH CLINICS, AND COUNCILOR DISTRICT MEETINGS | |
| 581 | Teaching Clinics, General | 1,000 |
| 582 | Industrial Health Clinics | 600 |
| 583 | Councilor District Meetings | 500 |
| 584 | Special Scientific Teaching Programs | |
| 5841 | "Medical Clinics on Mental Deficiency" | 300 |
| 5842 | MD–Dentist Clinics on Oral Cancer | 100 |
| 5843 | Industrial Health | 200 |
| 585 | Special Conferences | |
| 5851 | Four Conferences on Physicians and Schools | 1,000 |
| 59 | WISCONSIN MEDICAL JOURNAL | 4,200 |
| 5901 | VETERANS AGENCY AND PREPAID PLANS | |
| 59011 | Wisconsin Physicians Service | —— |
| 59012 | Wisconsin Plan | —— |
| 59013 | Experimental Programs | —— |
| 59014 | Veterans Medical Service Agency | 200 |
| 59015 | Actuarial Expense | —— |
| 5902 | INTERIM AND SPECIAL APPROPRIATIONS | |
| 59021 | Student Loan Fund | —— |
| 59022 | Veterans Medical Service Agency | —— |
| 59023 | State Historical Society, Survey of Medical Records and History | —— |
| 5903 | TRAVEL ACCOUNTS | |
| 59031 | Secretary's Travel—C. H. Crownhart | 2,000 |
| 59032 | Assistant Secretary's Travel—Roy T. Ragatz | 1,300 |
| 59033 | Director of Public Information Travel—Earl R. Thayer | $ 1,200 |
| 59034 | Field Secretary's Travel—Byron C. Ostby | 1,000 |
| 59035 | Claims Manager and SMS Consultant's Travel—Thos. J. Doran | 250 |
| 59036 | Medical Advisor's Travel (For radio activity)—Robert C. Parkin, M. D. | 250 |
| 59037 | Miscellaneous Travel | 300 |
| 5904–5 | EMPLOYEE TAXES AND INSURANCE | |
| 5904 | Group Insurance | 900 |
| 5905 | Employment Taxes | 1,500 |
| | Payroll as Reported in Payroll Budget | 88,165 |
| | Retirement Program | 4,700 |
| | Grand Total | $171,885 |

**Payroll Budget 1954**

| | |
|---|---|
| 1. Secretary | $ 20,000 |
| 2. Assistant Secretary | 11,500 |
| 3. Claims Director of Prepaid Plans and Veterans Agency Director, allocation from budget (total annual salary $11,250) | 1,200 |
| 4. Director of Public Information, allocation from budget (total annual salary $9,750) | 3,500 |
| 5. Field Secretary, allocation from budget (total annual salary $6,600) | 3,000 |
| 6. Comptroller, allocation from budget (total annual salary $9,000) | 4,500 |
| 7. Business Manager (proposed), allocation from budget (total 1954 salary from July 1, $3,000) | 600 |
| 8. Four positions of executive assistant | 14,800 |
| 9. Four positions of administrative assistant | 11,260 |
| 10. Six secretaries | 15,000 |
| 11. Two clerks | 2,805 |
| Total | $ 88,165 |

In the approval given the budget, it was understood that as in former years, unexpended appropriations in certain accounts are treated as carryovers, and in detail they are (estimated) as follows:

| Account | Budget Item | Appropriation |
|---|---|---|
| 561 | Applications and Correspondence | $ 400.00 |
| 562 | Panel Printing | 2,000.00 |
| 563 | Envelopes | 14.12 |
| 564 | Postage and Addressing Costs | 1,616.38 |
| 565 | Miscellaneous Expense | 300.00 |
| 581 | Teaching Clinics, General | 1,000.00 |
| | Total | $5,330.50 |

**5. Interim Report of the Secretary**

In addition to comments in his report on the budget, the secretary reported on general office activities and progress and developments of current projects.

**6. Elections**

a. Chairman of the Council—Doctor Griffith assumed the chair for this order of business,

and by unanimous vote Doctor Arveson was re-elected chairman of the Council for the ensuing year.

b. Treasurer—By unanimous vote Doctor Weston was re-elected treasurer of the Society for the ensuing year.

c. Secretary—By unanimous vote Mr. Crownhart was re-elected secretary of the Society for the ensuing year.

d. Editorial Director—By unanimous vote Doctor Sullivan was re-elected editorial director of *The Wisconsin Medical Journal* for a one-year term.

e. Medical Editor—By unanimous vote Doctor Baldwin was re-elected medical editor of *The Wisconsin Medical Journal* for a two-year term.

f. Member of the Interim Committee—By unanimous vote Dr. R. E. Galasinski was re-elected to the Interim Committee for the term expiring in 1957.

**7. Commission on State Departments**

Minutes of the January meeting of the Commission on State Departments, which indicated the comprehensive problems and projects of the various state departments, were circulated among Councilors and officers.

Within the minutes were recommendations as to the changes in the structure of the Commission itself, requiring Council action.

Original action of the Council in November 1952 as to membership and qualifications was as follows: "The commission itself shall consist of a general chairman and nine physicians, to be chosen by the Council of the State Medical Society at its Annual Meeting in each year, such members to serve for terms of one year. Those initially chosen shall serve until March 1, 1954."

It was recommended by the Commission that in order to coordinate terms of its division chairmen with Society activities, which begin immediately after the Annual Meeting of the Society, appointments be made by the Council at its meeting immediately preceding the annual session.

The secretary pointed out that with the rescheduling of the Annual Meeting of the Society to a spring date beginning in 1955, the time of the Council's annual meeting had not yet been determined; however, it was suggested that the recommendation of the Commission on State Departments could be accomplished by amending the November 1952 action of the Council.

On motion of Doctors Kasten–McCarey, carried, the Council acted to delete from the original material setting up the structure of the Commission on State Departments reference to the March 1 term of its chairmen in the last sentence of the material quoted above.

A further recommendation of the Commission on State Departments was to the effect that, in the future, division members be appointed for a three-year term, subsequently being ineligible for reappointment except after a two or three-year interval. There was lengthy discussion of this point.

On motion of Doctors Galasinski–McCarey, carried, the Council recommended that the matter of three-year terms for members on the various divisions of the Commission be reconsidered in one year.

On further motion of Doctors Kasten–McCarey, carried, the Council expressed its appreciation and commendation to the Commission on State Departments for its accomplishments to date.

The matter of nominations for chairmen of the nine subdivisions of the Commission on State Departments was taken up; and on motion of Doctors Ekblad–Costello, carried, the chairmen were unanimously reappointed as follows:

Tuberculosis and Chest Diseases—H. A. Anderson, M. D., Stevens Point

Maternal and Child Welfare—R. F. Purtell, M. D., Milwaukee

Visual and Hearing Defects—Maxine Bennett, M. D., Madison

Rehabilitation—R. G. Piaskoski, M. D., Wood

Geriatrics—J. A. Schindler, M. D., Monroe

School Health—E. H. Pawsat, M. D., Fond du Lac

Public Assistance—H. W. Carey, M. D., Lancaster

Crippled Children—H. A. Sincock, M. D., Superior

Nervous and Mental Diseases—E. D. Schwade, M. D., Milwaukee

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On motion of Doctors Tenney–Kasten, carried, Dr. T. W. Tormey, Jr., Madison, was reappointed general chairman of the Commission on State Departments.

**8. Report of the Committee on Public Policy on Chiropody**

It was reported by the Committee on Public Policy that a special study had been made and a recommendation submitted respecting amendment of the laws pertaining to chiropody. There was considerable discussion of the report.

On motion of Doctors Dessloch–Garrison, carried, the subject was returned to the Committee on Public Policy for further study.

**9. Amendment, Chapter XI, Section 3 of the By-Laws**

The last paragraph of Section 3, Chapter XI, of the By-Laws, having to do with county society membership, reads as follows:

"By proper provision of Constitution and By-Laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of three years from the date of such election, and shall not be included as a 'fully paid' member as that term is used in Section 2 of Chapter III."

In 1947 the Council instructed the secretary that the phrase underlined could be waived for those taking a five-year residency.

The secretary suggested that the Council recommend to the House of Delegates that it amend the by-law to read five years instead of three, as the present difference between administration and the actual wording of the by-law is causing confusion.

On motion of Doctors Garrison–Ekblad, carried, the recommended change in the By-Laws was approved for transmission to the House of Delegates.

**10. Report of the Council on Medical Service**

Mr. Earl Thayer presented the report of the Council on Medical Service and reviewed its recommendations with the Council.

The following items were submitted for Council action:

*A. March of Medicine on Television*

Information had been submitted to the Council previously concerning the necessity for immediate development of a television program along the lines of the March of Medicine program on radio. Numerous conferences have been held with respect to development of that program in cooperation with WHA–TV. From those conferences and through the Council on Medical Service, several principles were recommended governing the development of the production of this program. The principles were acted upon and approved, on motion of Doctors Garrison–Heidner, as follows:

(1) The program format is to be limited to situations typical to the average practicing physician's office and limited in respect to description of treatment.

(2) All shows will be approved prior to production by the State Medical Society.

(3) Prior to showing a kinescope of the WHA-TV production on any station, the State Medical Society will obtain approval from the county society in the county in which the station is located.

(4) All correspondence resulting from television programs shall be routed through the State Medical Society so that a consistent pattern can be developed for answering inquiries.

*B. Educational Television*

It was reported that the 1953 state legislature appropriated $75,000 for the development of a pilot educational television program at WHA, the state station, and that a state-wide referendum was planned for fall of 1954 on the question of whether there should be state-wide tax support of the educational television system in Wisconsin.

The Council on Medical Service recommended that the State Medical Society support this development but that financial contributions to groups supporting the development of the media be left to the discretion of individual physicians.

On motion of Doctors Ekblad–Zellmer, this recommendation was laid on the table.

*C. Report of the Committee on Nursing Education*

This committee of the Council on Medical Service has been studying the problem of nursing education and distribution in Wisconsin. It was reported that the proposal for a questionnaire survey of all R. N. nursing schools has been dropped for the time being. The committee believes that the most immediate need is a field study of the need of the Ashland area for a school for trained practical nurses and of the necessity for continuing such a school in operation in another area.

It was recommended, with approval of the Council on Medical Service, that an immediate study be made of these two problems. It was emphasized in the discussion that the study referred only to the school for trained practical nurses.

On motion of Doctors Dessloch–Fox, carried, Council approval was given to the recommended study.

*D. Tape Recording Loan Service*

The Council on Medical Service has reviewed the operation of the tape recording loan service for high schools for the 1953–54 school year. It was reported that the operation cost approximately $300 for that period and would be expected to require the same amount of money next year.

The Council on Medical Service feels this activity is one of the most successful public relations programs the Society has to offer. It was pointed out that such an activity provides opportunity for the Society to be of influence in giving young people information about proper health habits. The Council on Medical Service recommended that the program be continued for another year, without expansion, and expressed the hope that it might be possible in the future to obtain financial support from state or other organizations interested in public health and welfare.

On motion of Doctors Heidner–Costello, carried, the Council approved continuation of the tape recording loan service for another year.

**11. Report of the Commission on Prepaid Plans**

The report of the Commission on Prepaid Plans was presented as follows by its chairman, Dr. E. M. Dessloch:

## REPORT OF THE COMMISSION ON PREPAID PLANS TO THE COUNCIL OF THE STATE MEDICAL SOCIETY

February 1954

The last formal report to the Council was that preceding the Annual Meeting of the Society. This report constitutes a general review of 1953 and current developments in 1954.

THE THREE WISCONSIN "BLUE" PLANS
Contracts in Effect

| | Surgical Care | WPS | Blue Cross |
|---|---|---|---|
| 12–31–52 | 147,051 | 115,490 | 354,950 |
| 12–31–53 | 159,223 | 118,380 | 358,891 |
| *Growth | 12,172 | 2,890 | 3,941 |

*These figures do not include contracts negotiated in the meat packing industry, of which Surgical Care has 1,234; Physicians Indemnity Plan, 3,849; and Blue Cross, 5,163.

The Commission recognizes that the Blue Cross sales program has had unusual obstacles during the past two years. The new Blue Shield of Wisconsin program became effective July 1, 1952, and on a regular basis following that date it was necessary for Blue Cross to develop a conversion program from the old to the new. Then, within six months thereafter, a rate increase was determined by Blue Cross. Effective May 1, 1954, there will be a rate increase on the part of Blue Cross amounting to approximately 28 per cent. Thus, as to some joint installations of Blue Cross and Blue Shield, there are as many as three rate increases within a 16-month period. Blue Cross has taken steps which appear to promise a more aggressive sales program, and the future expansion of Blue Shield under the current policy of the Commission will be dependent almost entirely upon Blue Cross. There is no separate sales force acting in behalf of Blue Shield of Wisconsin. The Commission has authorized the position of sales coordinator, whose primary duty lies in explaining merit rating and in aiding in negotiations with large groups. Expansion of this service will be necessitated in 1954, for reasons further developed in this report.

### Staff Organization and Sales

The basic staff organization of WPS has now been completed. Major developments henceforth will be in the expansion of staff already acquired; specifically, the Commission believes that a certain fundamental sales organization appears to be a necessity. Several facts seem of significance:

(1) Over the course of the years since the organization of WPS, its growth and that of Surgical Care have roughly paralleled one another;

(2) Within these seven years of operation, never has Blue Shield been installed without Blue Cross; but Blue Cross has been installed without Blue Shield; and

(3) Despite the fact that the Commission on Prepaid Plans has authorized certain riders intended to broaden the scope and better the benefits of WPS, the new sale or addition of these riders to existing contracts is so nominal as not to be worth statistical reporting at this time.

Under current negotiations it is contemplated that Blue Shield will pay Blue Cross as agent a certain fixed amount per contract. Thus, it appears to be a fact of life that Blue Cross will find no financial benefit to itself in improving Blue Shield coverage on risks already covered. Such broadening of benefits would produce no added revenue to Blue Cross, as the number of contracts would not be affected.

On the other hand, there has been substantial installation of "A" coverage, which is strong indication that there is no design on the part of Blue Cross sales to negative Blue Shield broadened benefits. However, with the rate problem as outlined earlier, it is apparent that Blue Cross' primary efforts in the past two years have been directed to conservation and retention. That is important. But, nevertheless, it is of importance to Blue Shield as distinguished from Blue Cross that broadened benefits be installed wherever possible so that in the event of economic conditions necessitating installations receiving benefits at lower cost, some of the broadened benefits can be eliminated and the basic coverage retained.

It is in final but not too late appreciation of these facts that the Commission on Prepaid Plans will be asked, and undoubtedly will approve, the expenditure of sufficient funds to organize a very small, but it is hoped effective, sales staff to carry out the Blue Shield program in this limited area.

The Commission re-emphasizes that the minimal expansion of a staff under the direction of the sales coordinator is not to provide primary sales contacts, but to work in the problems developed out of large group installations and to meet the necessity, as the Commission sees it, of broadening Blue Shield benefits wherever possible.

### Blue Shield and Blue Cross Nationally

Councilors and officers who have followed the development of prepaid insurance will recall that pinpointed under direction of General Hawley, who at one time served as joint director for Blue Shield and Blue Cross in their national trade associations, there came about a proposal intended to facilitate the enrollment of so-called "national accounts"—that is, employees or members of common groups whose residence lay within the area of more than

one Blue Shield and Blue Cross plan. It was initially estimated that this problem affected 5 to 10 per cent of all individuals eligible for enrollment within the group protection of Blue Shield and Blue Cross.

It is not the purpose of this report to review past history of this development, but suffice it to say that the Council of the State Medical Society, in 1949, authorized participation by WPS so long as the following four conditions were met:

(1) Would not function in given area contrary to local plan.
(2) Include full payment. (No reference to indemnity)
(3) Include WPS income levels.
(4) Protect physician status.

The ultimate result in this whole field was the creation of two national insurance companies—one wholly owned by Blue Cross and known as Health Service, Inc., and the other wholly owned by Blue Shield and known as Medical Indemnity of America. These two organizations effected a joint operating agreement, so that while in theory they exist as individual companies, in actual fact they stand as merged. For—

(1) each company insures 50 per cent of whatever risks are acquired by the other, and
(2) the chief executive officer is a joint employee.

As these organizations were perfected and their operating procedures merged, the full significance and impact of the movement became discernible.

The two national organizations negotiated with the meat packing industry and in those negotiations developed plans that were either inconsistent or dissimilar to the local plans functioning within the various states. For example, Surgical Care of Milwaukee has long excluded home and office surgery from its benefits. But when the meat packing plan went into effect within the district covered by Surgical Care, home and office surgery was included as a benefit. In the state, Blue Shield of Wisconsin has long stood for the proposition that anesthesiology and radiology, in particular, should be provided as benefits of Blue Shield when those services were rendered and billed by a physician. When the national program was installed for Swift & Company employees and their families, no benefits along this line were included.

Oscar Mayer & Company itself has determined on a self-insured basis to provide certain benefits in radiology and in the laboratory and pathologic fields.

When it became a known fact that Health Service, Inc., the Blue Cross national agency, intended to install its surgical-medical contract and service its programs upon a number of individuals located in Wisconsin, the Commission on Prepaid Plans was confronted with a dilemma. If it accepted the national sales under the umbrella of Blue Shield of Wisconsin, it would find itself selling different Blue Shield benefits. If it failed to accept the national program, Blue Shield of Wisconsin would have Blue Shield of America sold within the state, which would be certain to produce confusion and misunderstanding.

Therefore, acting under prior authority of the Council, and within a matter of days, the Commission organized an indemnity plan known as Physicians Indemnity Plan, and all identification of the coverage in the Oscar Mayer & Company and Swift & Company installations in Wisconsin (outside of Milwaukee County) is now under that of P.I.P., a totally different instrumentality than that which is familiarly known as Blue Shield.

After many weeks of coverage in the Oscar Mayer & Company plant, the Commission still finds itself without the master Health Service insurance policy under which to apply the benefits contained within the P.I.P. program.

As a matter of fact, this delinquency in sound administrative practice marks such ineptness and ineffectiveness on the part of the national movement as to cause grave concern.

The Commission desires to report that it has done its best to produce some order out of chaos created by national Blue Cross in the first instance and aided and abetted by national Blue Shield in the second.

Of recent date there was circulated to Councilors, officers, and others a report on a national meeting in Chicago in which Blue Shield of Wisconsin took an active part, with 13 of its 17-member commission present.

This summary is accurate and detailed and meets with the approval of the Commission for its fact finding summary.

It may be added that Blue Cross of Wisconsin has expressed its concern over the development of the Physicians Indemnity Plan. Because of the benefit structure and limited premium and, more important, because of the decision of the Commission that the indemnity plan should in no manner be identified with Blue Shield, operation of the program was handled outside of the agency contract existing between Blue Shield and Blue Cross.

A joint meeting of committees of the Blue Cross Board of Directors and of the Commission on Prepaid Plans was held on February 20 to discuss, among other things, this particular development. It was pointed out to the Blue Cross representatives that the development in Wisconsin was not of the making of Blue Shield but the result of the activities of the national insurance company of Blue Cross. The Physicians Indemnity Plan created no problem not already created by national Blue Cross; if anything, it had eliminated some of those problems.

It has been agreed by both groups that periodic meetings will henceforth be scheduled, with agenda and topic preparation for advance study.

## Conclusion

There are times when our thinking as to prepaid health insurance and the participation of the medical profession may easily be affected by problems of the moment. Sound consideration of the whole subject must constantly be returned to the fundamental reasons for the profession to be concerned with the problem at all.

The principle of voluntary enterprise in the health insurance field is one of the major planks in the entire "platform" of the profession. The American Medical Association and its constituent state medical societies have repeatedly emphasized the point.

But voluntary insurance can and is being offered by the insurance industry as such. Why, then, should the medical profession be itself engaged in an active program of its own?

It is because the profession has a certain something to offer that no one else can offer. That is the concept of "full payment," under which the benefits provided are accepted by participating physicians in full payment for services rendered a defined income level.

With commitment to an insurance program such as Blue Shield of Wisconsin, there are concomitant problems which must be determined under the principle that what is best for public health is by reason of that fact best for the medical profession.

Some of these problems fall in the field of policy determinations. Others are of an administrative character. Still others might best be characterized as means to an end.

Principal among them is that the stature of Blue Shield cannot fall, directly or indirectly, under domination of forces whose ideals and whose training and obligations are not those of the profession itself.

Blue Shield can be advised by others, but it can be instructed only by formal action within the medical profession. These influences can emanate from many a diverse source. It may be the purchaser of the program who attempts to specify its content and is unappreciative of the complexity of insurance or that insurance itself can never insure what is a daily necessity of life. Nor should insurance become priced out of existence by the inclusion of minor benefits which, while perhaps of frequent occurrence, are individually small in dollar volume and expensive to administer.

These pressures also may develop under problems of delegating to Blue Cross as agent certain functions in behalf of Blue Shield. At the current writing of this report, the cost of the services performed by Blue Cross totals about two-thirds of the entire administrative cost of Blue Shield. Negotiations are being conducted to revise certain current agency contract provisions including the reimbursement formula. These negotiations have developed to a point where it may be anticipated that a certain "pegged" cost per contract will be the ultimate result. But with so much of the Blue Shield administrative cost committed to Blue Cross, the Commission's attitude is that those costs must be supported by Blue Cross in detailed and periodic reporting to Blue Shield. Furthermore, if mechanisms are developed to reduce administrative costs, then in fairness to Blue Shield subscribers, reduced administrative costs should be reflected to Blue Shield as well as to Blue Cross. Only by doing so is it possible for Blue Shield to represent adequately those who subscribe to its benefits. We have referred to "pressures"—we say that if Blue Cross does not adequately inform Blue Shield and is not in a position to justify its charges to Blue Shield, then Blue Cross is exerting an unreasonable pressure upon Blue Shield. That pressure is one of reserving to itself all powers of administrative decisions in the selling, enrolling, and billing fields; and in reserving all decisions to itself, it follows that Blue Cross welfare, not the welfare of Blue Shield and Blue Cross, becomes the decisive factor.

The Commission is following this matter as closely as possible. It is attempting to effect adequate liaison with the Blue Cross Board of Directors in the hope that both bodies will profit to the advantage of their respective programs and subscribers as each body becomes more keenly aware of the problems of the other.

The Council will be kept fully advised. Whether a special meeting may be necessitated in connection with the Blue Cross agency contract cannot be determined at this time, but the Commission will enter into no policy determination without full knowledge and consent of the Council.

Finally, the Commission must continue to be in the position it has asserted in the past—every tenet of the medical profession must be adhered to by Blue Shield. Blue Shield does not create those principles nor is it Blue Shield's responsibility to change them. Such responsibility is that of the medical profession through its various professional associations.

The medical profession holds that free choice of physician advances sound quality of medical care. Blue Shield complies with that principle.

The medical profession holds certain services in the specialty field to be medical services, benefits for which should be included in the Blue Shield contracts; and Blue Shield of Wisconsin complies.

The medical profession in Wisconsin holds that adequate standards of medical practice should be reviewed and controlled by the profession, and that if a question is raised concerning a specific physician, this is a matter for the medical profession to handle, at least in the first instance. Blue Shield complies.

In short, Blue Shield of Wisconsin is an integral part of the whole of medicine. It will be continued that way.

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Wisconsin Physicians Service financial statements for December 1953 follow:

**WISCONSIN PHYSICIANS SERVICE**
**Madison, Wisconsin**
**BALANCE SHEET**
**December 31, 1953**

| | | |
|---|---|---|
| **Assets** | | |
| Cash on Hand and in Banks | | $ 457,254.12 |
| Cash on Deposit with Agent | | 117,000.00 |
| Due from Agent | | 152,907.07 |
| Advance to Physicians Indemnity Plan of Wisconsin | | 25,000.00 |
| Refunds Receivable | | 2,677.00 |
| U. S. Government Bonds—Net | $1,272,344.76 | |
| Less: Reserve for Excess of Book Value over Market Value | 2,435.72 | |
| | $1,269,909.04 | |
| Accrued Interest Income | 3,086.99 | 1,272,996.03 |
| Office Furniture and Fixtures—Net | | 15,006.38 |
| Total Assets | | $2,042,840.60 |
| **Liabilities and Reserves** | | |
| Accounts Payable | | $ 3,915.69 |
| Accrued Expense | | 739.51 |
| Merit Rating Credits Payable | | 13,049.15 |
| Physicians Claims Payable | | 346,840.81 |
| Reserve for Old Outstanding Checks | | 2,449.50 |
| Unearned Income | | 388,361.05 |
| Reserves—Maternity Benefits | $ 186,600.00 | |
| Disaster Claims | 202,760.00 | |
| Unforeseen Contingencies | 505,633.95 | |
| Administrative | 356,536.62 | |
| Investment | 35,954.32 | 1,287,484.89 |
| Total Liabilities and Reserves | | $2,042,840.60 |

**WISCONSIN PHYSICIANS SERVICE**
**Madison, Wisconsin**
**COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES FOR THE PERIODS JANUARY 1 TO DECEMBER 31, 1952 and 1953**

| | 1-1-53 to 12-31-53 | 1-1-52 to 12-31-52 | Increase or (Decrease) |
|---|---|---|---|
| **Income** | | | |
| Earned Premium Income | $3,910,994.72 | $2,656,352.72 | $1,254,642.00 |
| Other Administrative Income | 781.89 | | 781.89 |
| Investment Income | 17,664.62 | 12,640.00 | 5,024.62 |
| Total Income | $3,929,441.23 | $2,668,992.72 | $1,260,448.51 |
| **Expenditures** | | | |
| Benefits Incurred | $2,983,567.05 | $2,061,340.95 | $ 922,226.10 |
| Expenses of Agent | 345,429.98 | 259,317.36 | 86,112.62 |
| Salaries | 113,436.15 | 85,203.51 | 28,232.64 |
| Legal Expense | 8,413.54 | 8,502.49 | ( 88.95) |
| Auditing Expense | 9,617.72 | 9,275.50 | 342.22 |
| Actuarial Expense | 8,060.80 | 8,613.34 | ( 552.54) |
| Conference Expense | 12,962.76 | 10,785.94 | 2,176.82 |
| Staff Travel | 6,594.48 | 3,456.61 | 3,137.87 |
| Stationery and Supplies | 11,077.60 | 7,980.87 | 3,096.73 |
| I.B.M. Expense | 8,793.42 | 2,056.99 | 6,736.43 |
| Rent | 9,900.00 | 6,804.00 | 3,096.00 |
| Office Expenses | 2,234.92 | 2,430.49 | ( 195.57) |
| Postage and Express | 4,731.39 | 4,194.93 | 536.46 |
| Payroll Taxes | 3,057.79 | 1,947.76 | 1,110.03 |
| Telephone and Telegraph | 4,922.28 | 5,529.23 | ( 606.95) |
| Employees' Group Insurance | 1,603.54 | 1,143.80 | 459.74 |
| Depreciation | 2,956.83 | 1,552.58 | 1,404.25 |
| Insurance | 589.40 | 478.73 | 110.67 |
| Association Dues | 3,467.92 | 3,100.42 | 367.50 |
| Other Administrative Expenses | 2,731.46 | 398.27 | 2,333.19 |
| Total Expenditures | $3,544,149.03 | $2,484,113.77 | $1,060,035.26 |
| Available for Reserves | $ 385,292.20 | $ 184,878.95 | $ 200,413.25 |
| **Distribution of Each $100.00 of Income** | | | |
| Benefits Incurred | $ 75.93 | $ 77.23 | $( 1.30) |
| Expenses of Agent | 8.79 | 9.71 | ( .92) |
| Other Administrative Expenses | 5.47 | 6.14 | ( .67) |
| Addition to Service Benefit Reserve | 5.63 | 4.41 | 1.22 |
| Addition to Administrative Reserve | 3.73 | 2.02 | 1.71 |
| Addition to Investment Reserve | .45 | .49 | ( .04) |
| | $ 100.00 | $ 100.00 | $ |

On motion of Doctors Galasinski–Costello, carried, Council approval was given to the report of the Commission on Prepaid Plans.

### 12. Mr. E. Harold Hallows

At the special invitation of Chairman Arveson, Mr. E. Harold Hallows, president of the Wisconsin Bar Association, appeared before the Council and expressed appreciation of the Bar Association for the State Medical Society's co-sponsorship in the Legal-Medical Institute held during the midwinter meeting of the Wisconsin Bar Association in Milwaukee. He said he hoped such a program could be an annual affair and pointed out the need for understanding between the two professions, adding that such an understanding might be further developed through adoption of the proposed Code of Interprofessional Ethics.

Mr. Crownhart called attention to a draft of the Code of Professional Ethics between the medical and legal professions, which was submitted only for Council information at present. He requested that Councilors review the drafted code at their leisure and advise him of their reactions.

### 13. Veterans Medical Service Agency

The Veterans Medical Service Agency is under contract with the Veterans Administration, using a schedule of fees negotiated about four years ago.

This schedule is frequently consulted by other governmental agencies, including county relief agencies.

Because the schedule is obviously outdated at this time, the chairman of the Operating Committee of that agency suggests the advisability of its endeavoring to renegotiate the schedule prior to renewal of the contract with the Veterans Administration, effective July 1. This would necessitate a trip to Washington; and since the expense of such a trip is nonrecoverable against the VA, it was pointed out that Council approval was required for such expenditure.

On motion of Doctors Galasinski–Bell, carried, necessary expense for the proposed trip was approved.

### 14. Authority to Commission on Prepaid Plans

The secretary reminded Councilors and officers that financing of the new State Medical Society building is contemplated through the taking of a first mortgage in the name of Wisconsin Physicians Service to the extent permitted under insurance regulations. He pointed out that, while the Commission on Prepaid Plans has broad authority in making of investments, it appeared wise that the authority be specific in this instance.

On motion of Doctors Bell–Galasinski, carried, the Commission on Prepaid Plans was authorized to loan money to the SMS Realty Corporation, such loan to be on appropriate terms as permitted by the State Insurance Department and to be secured by a first mortgage upon the premises and building.

**15. The Migrant Worker**

The Council on Medical Service previously authorized appointment of a special one-term committee to consider the medical problems created by the influx of more than 12,000 migrant workers during the late summer of each year. These workers furnish the labor that has enabled Wisconsin to excel in agricultural production.

Mr. Roy Ragatz spoke to the Council on behalf of the committee and, in reviewing its report, pointed out that although the migrant workers, and particularly those from other countries, are under certain health regulations as to examinations, etc., yet because of their peculiar "temporary status" here, in their health needs they present a different picture to the practicing physician than his "resident" patients.

He said that the committee proposed preparation of a special guide, suggesting mechanisms for handling medical care problems of these individuals, to be circulated to county societies, camp operators, and others. The guide was submitted and reviewed. Mr. Ragatz explained that county medical societies in areas concerned would be expected to supplement the bulletin by preparing a list of physicians available for service, to develop a "sick call" program, provide mechanisms for emergency service, and provide for similar matters.

In the ensuing discussion Council members expressed themselves as being in favor of such a program.

On motion of Doctors Kasten–McCarey, carried, they approved preparation of the guide as presented and development of the proposed program.

**16. Conference Committee on Open Panels**

As a supplementary report of the Council on Medical Service, Mr. Ragatz reported that the Conference Committee on Open Panels, serving as a subcommittee of the Council on Medical Service, recommended that, with the distribution of the 1954-55 Workmen's Compensation applications to physicians and participating insurance companies, a statement be sent outlining the responsibilities of all parties concerned with the Open Panel on certain subjects which have caused some complaint on the part of physicians, the insurance carriers, and the Industrial Commission.

The statement, as approved by the Council on Medical Service, was reviewed; and in the discussion, Mr. Ragatz said it was believed that distribution of the material would obviate misunderstandings and complaints which have occurred in the past.

On motion of Doctors Bell-Dessloch, carried, the Council approved the report and recommendations of the Conference Committee on Open Panels.

**17. State Board of Medical Examiners**

As a special order of business, and because it was meeting in Milwaukee on its own affairs, the State Board of Medical Examiners was invited to meet with the Council.

Dr. J. W. Prentice, Ashland, president of the Board, introduced each of the Board members, with the exception of Dr. E. C. Murphy, who was unable to be present. Doctor Prentice asked each of the members to speak briefly on activities and problems of the Board of Medical Examiners. In this form various problems and recommendations were presented relative to the Medical Practice Act. Doctor Prentice said he looked forward to joint meetings of the State Board of Medical Examiners with the Council and representatives of the State Medical Society in order to solve jointly problems of public health and the profession generally. Doctor Prentice expressed the further hope that a committee of the Board may meet with the Society's legislative committee in an effort to work out legislative recommendations.

On behalf of the Council, Doctor Arveson thanked the Board of Medical Examiners for its presentation and extended an invitation to make such a meeting an annual affair.

**18. Adjournment**

There being no further business, the annual meeting of the Council was adjourned at 12:20 p.m., Sunday, February 28.

C. H. Crownhart,
*Secretary*

Approved:
R. G. Arveson, M.D.,
*Chairman of the Council*

## AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY CERTIFICATION

Applications for certification (American Board of Obstetrics and Gynecology) for the 1955 Part I Examinations are now being accepted. Candidates are urged to make such application sometime in July or August. All candidates for admission to the examinations are required to submit, with their application, a plain typewritten list of all patients admitted to the hospitals where they practice for the year preceding their application or the year prior to their request for reopening of their application, with the diagnosis, pathological diagnosis, nature of treatment, and end result.

Application for examination or re-examination, as well as requests for resubmission of case abstracts, must be made to Robert L. Faulkner, M. D., Secretary, 2105 Adelbert Road, Cleveland 6, Ohio, prior to October 1, 1954. Under a change of requirements for the Part I Examination, candidates must submit 20 case abstracts rather than 25 as formerly. Five of these may be from one's residency service.

# Society Proceedings

## Barron—Washburn—Sawyer—Burnett

*Dr. Anthony Curreri*, professor of surgery at the University of Wisconsin Medical School, Madison, spoke on "Tumors of the Breast" at the May meeting of the Barron–Washburn–Sawyer–Burnett County Medical Society held at the Rice Lake Elks Club on May 11. Prior to the meeting, the physicians attended an open house given by *Drs. W. B.* and *O. E. Rydell* at their new Rice Lake Clinic building.

Doctor Curreri was accompanied by Dr. Enrico Polletti, a physician on the faculty of the medical school at the University of Florence, Italy. The Italian doctor is studying at the University of Wisconsin.

## Dodge

On June 12 the members of the Dodge County Medical Society held a dinner meeting with the Dodge County Medical Society Auxiliary at the Waupun Country Club. They participated in an afternoon of golf before the meeting.

## Outagamie

Dr. Edwin M. Miller, Chicago, a nationally known surgeon, spoke to 62 members and 24 doctors from surrounding counties at a meeting of the Outagamie County Medical Society held on May 20 at the Appleton Elks Club. Doctor Miller talked on surgery of the gallbladder, surgical aspects of peptic ulcer and various diseases of the intestines, surgery of children, and surgery of the esophagus and stomach.

Doctor Miller is chairman of the department of surgery at Presbyterian Hospital, Chicago, and professor of surgery at the University of Illinois College of Medicine; and he has been attending surgeon at the Cook County Hospital for 26 years. Doctor Miller's Appleton appearance was arranged through the efforts of *Dr Victor F. Marshall.*

## Polk

On May 20 the members of the Polk County Medical Society met at Paradise Lodge, Balsam Lake, to hear Dr. Irvin Moore, a pediatric allergist from Minneapolis, speak on "Infant Allergy." The paper was illustrated by a colored film made by the speaker for the Borden Milk Company.

At the business portion of the meeting, *Dr. H. A. Dasler* of Amery explained the first Polk County Mental Health Conference which was to be held the first week in June. *Dr. Robert M. Moore*, Frederic, discussed the Blue Shield–Blue Cross plans in the county.

## Price—Taylor

The public library in Phillips was the meeting place for the members of the Price–Taylor County Medical Society when they held their meeting on May 22. *Dr. William Young*, Madison, of the University of Wisconsin Medical School, spoke on "Cancer of the Rectum and Large Bowel." *Drs. J. J. Leahy, E. B. Elvis, J. L. Murphy, J. D. Leahy,* and *J. L. Rens* joined in the discussion.

Officers for the coming year were elected. They are:

President—*Dr. E. B. Elvis*, Medford
Vice-President—*Dr. W. E. Niebauer*, Phillips
Secretary—*Dr. James J. Leahy*, Park Falls.

## Walworth

*Dr. Maurice J. Reuter*, assistant clinical professor of dermatology at Marquette University School of Medicine, spoke to the members of the Walworth County Medical Society on May 13 at the Colonial Hotel in Delavan. Doctor Reuter discussed "Dermatoses of the Hands and Feet, Diagnosis and Treatment," and used Kodachrome slides to illustrate his talk.

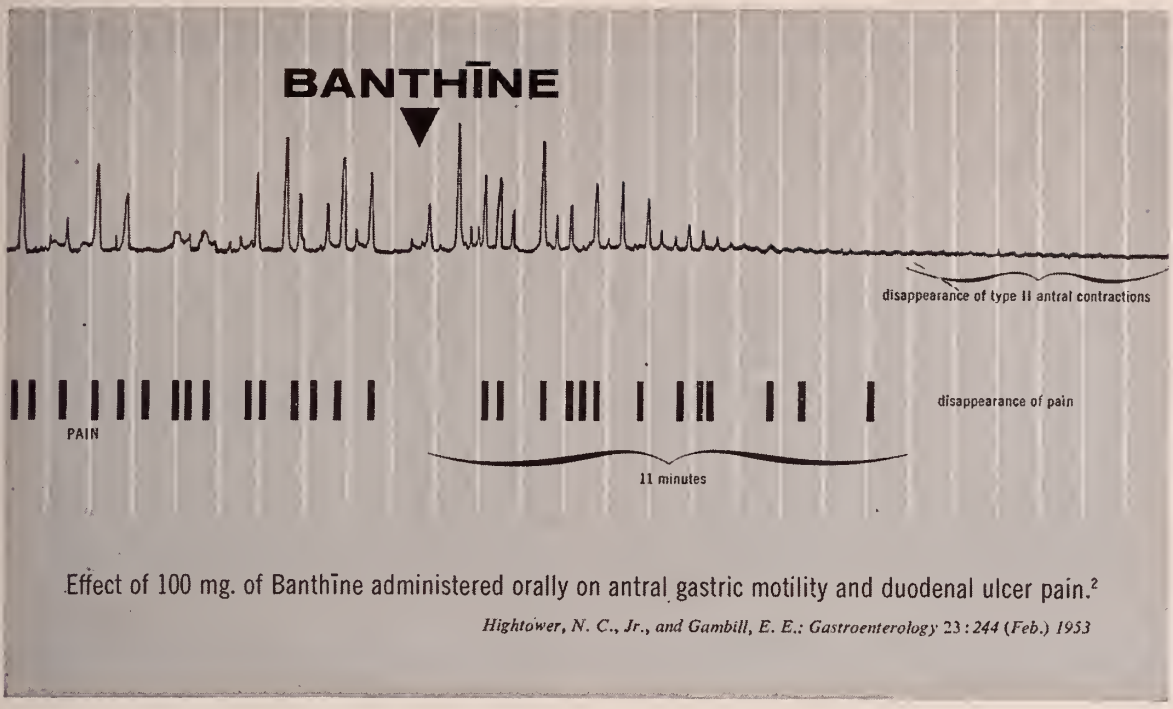
Mr. David Nugent and Mr. Robert Towne discussed a tentative program for Blue Cross and Blue Shield non-group enrollment.

At the business portion of the meeting an officers' report stated that the officers of the society had met with the new county welfare agent at a dinner meeting, extended a welcome from the county society, and assured the agent of cooperation from the society.

## Washington—Ozaukee

Twenty-five members of the Washington–Ozaukee County Medical Society and their wives were present at the May 27 meeting held at Linden Inn, Big Cedar Lake. The meeting was held in honor of *Dr. J. G. Hoffmann*, Hartford, on the occasion of his 50th year in the practice of medicine. *Dr. Dexter H. Witte*, Milwaukee, was master of ceremonies and related many humorous incidents from the years during which he was associated with Doctor Hoffmann. Doctor Hoffmann reminisced about past experiences, especially those during the horse and buggy and early automobile eras.

The American Medical Education Foundation was discussed, and definite conclusions were passed involving each society member. The migrant worker situation was also discussed during the business session.

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*Hightower, N. C., Jr., and Gambill, E. E.: Gastroenterology 23:244 (Feb.) 1953*

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*Ruffin, J. M.; Texter, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.*

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### Winnebago

Members of the Winnebago County Medical Society met on June 3 to hear *Dr. Kenneth E. Lemmer*, Madison, professor of surgery at the University of Wisconsin Medical School, speak on "Surgical Treatment of the Diseases of the Colon." The meeting was a dinner meeting held at the Athearn Hotel in Oshkosh.

### Wood

*Dr. J. K. Theisen*, Marshfield, spoke to the members of the Wood County Medical Society on May 13 at the Hotel Charles in Marshfield. Doctor Theisen discussed "Pain in the Shoulder, Arm and Hand."

### Wisconsin Heart Association Honors Doctors

Eight doctors were among 23 Wisconsin organizations and individuals who had conducted the Heart Fund Drive for three or more years and were presented with the Wisconsin Heart Association distinguished service award by Wilbur Renk, Sun Prairie, at the Wisconsin Heart Association annual meeting on June 5 in Madison.

Those doctors honored by the association were *Dr. William Stovall, Jr.*, Brodhead; *Dr. Sam S. Sorkin*, Evansville; *Dr. Vincent W. Koch*, Janesville; *Dr. George R. Barry*, Monroe; *Dr. Herbert F. Scholz*, Thiensville; *Dr. James S. Mubarak*, Tomah; and *Dr. William S. Middleton*, Madison.

### Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

A two-day program was attended at the Hotel Foeste, Sheboygan, by members of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology on June 5 and 6. The program opened on Saturday morning with golf at the Pine Hills Country Club, Sheboygan. During the afternoon Dr. Eugene Folk, Chicago, spoke on "An Evaluation of Accommodative Element in Esotropia." Dr. Stanton A. Friedberg, Chicago, followed Doctor Folk on the program with a discussion of "Orbital Lesions of Interest to Ophthalmologists and Otolaryngologists." A movie, "African Safari," was shown by *Dr. Otis M. Wilson*, Wausau, following dinner.

Sunday began with a business session, which was followed by a talk by Doctor Folk on "Treatment of Amblyopia." Doctor Friedberg then conducted a Kodachrome clinic on laryngeal pathology. The program concluded with a general discussion period.

# News Items and Personals

### Dr. D. P. Epperson in Watertown

Now associated with *Dr. Raymond Welbourne* in the practice of general surgery at Watertown is *Dr. Dean Paul Epperson*. Doctor Epperson was graduated from Harvard Medical School in 1945 and after interning at the Boston City Hospital, he entered the Army and spent two years in diagnostic radiology in San Antonio, Texas, at Lackland Air Base Hospital. He left the armed forces with the rank of captain in 1948 and was associated with his father in the private practice of roentgenology in Milwaukee for six months prior to beginning a surgical fellowship at the Mayo Clinic, Rochester, Minnesota. During his four and one half years at the clinic, he received the degrees of M. S. in surgery and Ph.D. in surgery and biochemistry from the University of Minnesota. Doctor Epperson is a diplomate of the American Board of Surgery.

### Doctor Jensen Returns to Green Bay

After two years in the Navy, *Dr. Richard E. Jensen* has returned to Green Bay to resume his practice with *Drs. Robert Rose* and *Thomas Burdon* at the Burdon–Rose Clinic. Doctor Jensen served seven months of his tour of duty in the Korean waters in a squadron attached to Task Force 95.

### Watertown Physician to Start Residency

*Dr. John C. Brazos* has announced that he has closed his office in Watertown to start a four-year residency in general surgery at Milwaukee County Hospital. Doctor Brazos, who has been practicing in Watertown for three years, was graduated from the University of Illinois and interned at Ancker Hospital, St. Paul, Minnesota.

### Kenosha Physician Now Practicing in Merrill

*Dr. W. E. Braun*, who has been practicing in Kenosha, has moved to Merrill, where he will have an office. He was a graduate of Marquette University School of Medicine in 1945 and interned at the U. S. Navy Hospital, San Diego, California. Following his release from the Navy in December 1947, he spent three years in residency in orthopedic surgery in Milwaukee. He was at the Veterans Hospital, Wood, for two years and at the Milwaukee Children's Hospital for one year. He practiced bone and joint surgery at the Veterans Hospital, Iron Mountain, Michigan, in 1951 and then entered private practice in Kenosha.

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## Doctor Jackson Speaks in Neenah

*Dr. Arnold Jackson,* Madison, spoke to the Theda Clark Nurses Alumnae Association on June 10 in Neenah. The meeting was held at the nurses home of Theda Clark Hospital.

Doctor Jackson is chief of staff at the Methodist Hospital and director of the Jackson Clinic, Madison. He is president-elect of the American Chapter of the International College of Surgeons.

## Doctor Gorenstein Leaves La Crosse

*Dr. L. M. Gorenstein* has left La Crosse to take a three-year residency in psychiatry at the University of Indiana in Indianapolis. He had practiced in La Crosse since 1945.

*Dr. Joseph Richter,* who has been in practice in Chaseburg for the past 12 years, is taking over Doctor Gorenstein's practice.

## Dr. O. C. Clark Accepts Position at Milwaukee County Asylum

Having resigned his position as medical director at Rogers Memorial Sanitarium, Oconomowoc, *Dr. O. C. Clark* has accepted the position of assistant medical director at Milwaukee County Asylum, Wauwatosa. He was on the Rogers Memorial staff for nine years prior to World War II and returned as medical director of the sanitarium four years ago.

Doctor Clark was certified as a mental hospital administrator by the American Psychiatric Association at a meeting in St. Louis early in May.

## Dr. R. L. Gilbert Speaks in Sparta

At the monthly staff meeting of the St. Mary's Hospital in Sparta, *Dr. Robert L. Gilbert,* specialist in internal medicine at Grandview Clinic, La Crosse, spoke on heart sounds and their significance in clinical practice. He also reviewed a case presentation on congenital heart disease.

## Doctor Lundmark Observes Fiftieth Year of Practice

On June 2, 1904, *Dr. Lambert M. Lundmark,* Ladysmith, received his license to practice medicine from the University of Minnesota. This year he observed his 50th year as a country doctor. In an editorial honoring Doctor Lundmark, the *Ladysmith News* said, "No other doctor has ever practiced medicine that long in Rusk County. Few men anywhere have given such long service to humanity in one of the most trying and difficult professions known to man—that of the country doctor.

"When Lundmark came to Rusk County, Ladysmith was little more than a backwoods community.

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"The last fifty years in Rusk County have been richer for the presence of Lambert Lundmark . . ."

## Doctor Thompson to Leave Argyle

*Dr. L. L. Thompson* has announced that he will leave Argyle to become a specialist in radiology. He is planning to take a three-year residency, two years at the Veterans Administration Hospital in Wood, and one year at the Milwaukee Children's Hospital. Doctor Thompson has practiced in Argyle for the past four years.

## Antigo to Lose Doctor Thomas

*Dr. W. C. Thomas* will leave Antigo about July 5 to settle on the west coast of Florida, possibly Key West. Doctor Thomas has practiced in Antigo for two years.

Mrs. Thomas, who was recently elected president of the Langlade County Medical Auxiliary, was honored at a luncheon at the McMillion Hotel on June 4.

## Doctor White Speaks in Milwaukee

When the institute on modern treatment of tuberculosis was held for Milwaukee health and welfare workers in Milwaukee on June 7, at Marquette University's Brooks Memorial Union, *Dr. Ellison White* spoke to the group. The institute was sponsored by the Wisconsin Anti-Tuberculosis Association.

Doctor White is the superintendent and medical director at the state sanatorium at Wales. He outlined four things which sanatorium care gives; namely, isolation, education, regimentation, and rehabilitation.

## Doctor Newcomb Honored Over Memorial Day

*Dr. Kate P. Newcomb*, Woodruff, was honored over Memorial Day by the million penny paraders of the Arbor Vitae–Woodruff High School. A "Dr. Kate Day" climaxed the latest fund raising campaign conceived by the penny paraders during which they sold seals bearing the picture of the woman physician. The proceeds from sale of the seals went toward retiring the debt on the Lakeland Memorial Hospital. The nearly completed hospital will be in Doctor Newcomb's charge.

## THIRD AND TWELFTH DISTRICTS NEWS

### Doctor Llewellyn Elected President of Wisconsin Association of Blood Banks

*Dr. M. B. Llewellyn,* Janesville pathologist, was elected president of the Wisconsin Association of Blood Banks at its annual meeting in Milwaukee on May 15. Doctor Llewellyn was a leader in the founding of the state association, which was organized in 1951 and now has 23 institutional members, including the Junior League Blood Center of Milwaukee, the Badger Regional Blood Center of Madison, and 21 hospital blood banks scattered throughout the state.

### Dr. Thomas Allin Appointed New Coroner

Governor Walter Kohler has appointed *Dr. Thomas Allin, Jr.,* Plain, as the new coroner for Sauk County. Doctor Allin was graduated from the University of Wisconsin Medical School in 1949 and succeeded *Dr. Yoshio Handa,* Hines, Illinois, in practice at Plain over a year ago.

### Dr. John Schroeder Opens Madison Office

An office for the general practice of medicine has been opened in Madison by *Dr. John Schroeder.* He received his medical degree in 1951 from the University of Wisconsin. He interned at City Hospital in Louisville, Kentucky, and served a year's residency in general practice in the general hospital at the University of Michigan. Doctor Schroeder is a native of Racine.

### Doctor Masten Moves to Florida

After 28 years at the University of Wisconsin General Hospital, Madison, *Dr. Mabel G. Masten* has become associated with the Veterans Administration Regional Office in Miami, Florida. Doctor Masten began her new association on June 1.

### Milwaukee Neuro-Psychiatric Society

The annual meeting of the Milwaukee Neuro-Psychiatric Society was held on May 19. New officers for the coming year were elected. They are:

President—*Dr. Francis J. Millen*
Vice-President—*Dr. John T. Petersik*
Secretary–Treasurer—*Dr. I. J. Sarfatty*

Councilors include *Dr. Owen C. Clark* and *Dr. Benjamin A. Ruskin.*

### Chief of Staff Elected at St. Joseph's Hospital, Milwaukee

*Dr. Samuel Rosenthal* has been elected chief of staff at St. Joseph's Hospital, Milwaukee, it was announced on May 27. New department heads are


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*Dr. William L. Coffey, Jr.*, medicine; *Dr. James R. Regan*, orthopedics; *Dr. James C. Sargent*, urology; *Dr. E. A. Waldeck*, eye, ear, nose, and throat; *Dr. Francis E. Kehlnhofer*, general practice; and *Dr. Joseph M. Regan*, physical medicine.

## Milwaukee Gynecological Society

The Milwaukee Gynecological Society held its election of officers at a meeting at the Wisconsin Club on May 24. The following officers were elected:

President—*Dr. F. J. Hofmeister*
Vice-President—*Dr. William F. Hovis, Jr.*
Secretary–Treasurer—*Dr. L. T. Servis*

These officers replace the following outgoing officers: *Dr. David J. Werner*, president; *Dr. Lester H. Verch*, vice-president; and *Dr. William F. Hovis, Jr.*, secretary–treasurer.

## SOCIETY RECORDS

### New Members

W. H. Heywood, Winnebago State Hospital, Winnebago.

R. E. Holzgrafe, 1527A South 13th Street, Milwaukee.

Elaine M. Thomas,** City Health Department, City Hall, Milwaukee.

Evlyn M. Anderson, 905 University Avenue, Madison.

E. H. Johnson, 3925 Hammersley Avenue, Madison.

Pearl M. Loveland, 110 East Main Street, Madison.

K. R. Petsch, 16 South Henry Street, Madison.

G. G. Rowe, 1300 University Avenue, Madison.

J. M. Schroeder, 3414 Monroe Street, Madison.

D. M. Gallaher, Jr., 103 West College Avenue, Appleton.

J. W. Schaller, 480 East Grand Avenue, Wisconsin Rapids.

D. E. Hoff, 314 East Grand Avenue, Eau Claire.

### Changes of Address

R. A. Flynn,* San Francisco, California, to 9 La-Fayette Drive, Columbus, Georgia.

J. R. Allen, Waunakee, to 2805 East Washington Avenue, Madison.

C. M. Kelly, Sonoma, California, to 531 North 24th Street, La Crosse.

Tokuso Taniguchi, Fort Lewis, Washington, to Hawaii Planing Mill, Ltd., Hilo, Hawaii.

J. L. Raschbacher, Kewaskum, to Big Bend.

Ann Bardeen Henschel, Madison, to Prince Albert Sanatorium, Prince Albert, Saskatchewan, Canada.

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Thomas Morrison, Wood, to 904 North Prairie Avenue, Joliet, Illinois.

L. E. Jones, Milwaukee, to 617 14th Street, Racine.

Earl Sullivan, Monroe, to 538 West Main Street, Madison.

Stanley Schilling, Monroe, to Samual Mahelona Memorial Hospital, Kealia, Kauai, Hawaii.

O. C. Clark, Waukesha, to 9035 Watertown Plank Road, Milwaukee.

Mabel G. Masten, Madison, to 212 N.W. 93rd Street, Miami, Florida.

Lonnie C. Grant, Jr., New York, to 1716 Bull Street, Columbia, South Carolina.

F. N. Peterson, Oconomowoc, to Blessed Marten's Villa, Kingston, Jamaica, B.W.I.

Jonathan Slomowitz, Great Lakes, Illinois, to 836 West Mitchell Street, Milwaukee.

G. V. Hering,* Jacksonville, South Carolina, to U.S.N.R., Navy Number 115, Box 36, Fleet Post Office, New York, New York.

E. C. Ferguson, Waupun, to 176 Oak Street, Juneau.

E. K. Rath, Mukwonago, to 4241 North 44th Street, Milwaukee.

G. V. Muscato, Fort Campbell, Kentucky, to 114 LeVan Avenue, Lockport, New York.

R. A. Starr,* Viroqua, to 11 Nunutz Drive, Apartment 1, Astoria, Oregon.

H. M. Bachhuber,* Neosho, Missouri, to 316 Pine Street, Sparta.

T. A. Burns, Milwaukee, to 4212 N.E. Broadway, Portland 13, Oregon.

*Military Service.
**Reinstated member.

## DEATHS

**Dr. Maurice J. Ansfield**, 46, widely known Milwaukee physician, died at Mount Sinai Hospital, Milwaukee, on May 26.

A graduate of the University of Wisconsin in 1932, Doctor Ansfield had served part time as deputy superintendent of the Bureau of Contagious Diseases and School Hygiene of the Milwaukee Health Department from 1938 to 1944. For two years previously he was clinic physician for the health department. From 1934 to 1936, he was resident physician at Johnston Emergency Hospital. He also served as resident physician at the Milwaukee County General Hospital, where he had interned. He did postgraduate work at Michael Reese Hospital and at Jefferson Medical School. At the time of his death, he was on the attending staffs of the Milwaukee County General Hospital and Mount Sinai Hospital and was a member of the faculty of Marquette University School of Medicine.

A practicing physician in Milwaukee for 18 years, Doctor Ansfield was a Fellow in the American College of Physicians and a Diplomate of the American Board of Internal Medicine. He was a member

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J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Earl H. Ninow, M. D.
Paul J. Lawler, M. D.

of the Medical Society of Milwaukee County, the State Medical Society, the American Medical Association, and the American Heart Association.

Doctor Ansfield was commissioned as a lieutenant in the Navy during World War II.

He is survived by his widow, Esther; three sons, Donald, Thomas, and James, all of Milwaukee; four brothers, Samuel, Arnold, and Dr. David, all of Milwaukee, and Dr. Fred, Glidden, Wisconsin; and a sister, Mrs. Frieda Salgonick of New York City.

**Dr. Thad W. Ashley**, 80, eye, ear, nose, and throat specialist from Kenosha, died on May 18 after a long illness. He was born on April 6, 1874, in Steuben, Ohio, and had practiced in Kenosha since 1913.

He was graduated from Miami Medical College, now the University of Cincinnati, in 1901 and did postgraduate work at the University of Vienna, Austria, in 1923 and at the University of Bordeaux, France, in 1928. Before coming to Kenosha, Doctor Ashley had practiced medicine in Willard, Ohio, and had been a physician and surgeon in the relief department of the Baltimore and Ohio Railroad in Newark, Ohio. He was associated with the Prince Eye, Ear, Nose, and Throat Hospital in Springfield, Illinois.

The doctor was regarded as chiefly responsible for the numbering system used to designate city streets and avenues in Kenosha. A past president of the Kenosha County Medical Society, he was a member of the State Society and the American Medical Association. In 1951 he was honored as a member of the 50 Year Club of the State Society. He was also a life member of the American Academy of Ophthalmology and Oto-Laryngology.

In addition to his widow, Jesse, he is survived by two daughters and a son, Mrs. Robert E. Hoffhines, Columbus, Ohio, Mrs. W. Ogden Vogt, Birmingham, Michigan, and Dr. Richard Ashley, Kenosha; a sister, Mrs. F. C. Schorndorfer, Columbus, Ohio; and 13 grandchildren.

**Dr. Robert J. Bach**, 67, a physician and surgeon in Milwaukee for many years, died on June 5 at St. Mary's Hospital, where he was former chief of staff.

Doctor Bach was born on January 12, 1887, in Milwaukee and was graduated from Marquette University School of Medicine in 1913. A close friend and business associate, Dr. C. J. Corcoran, was graduated in the same class with Doctor Bach and they practiced together. They attended the University of Vienna together in 1934, studying gastrointestinal diseases, and later specialized in treatment of those diseases.

Doctor Bach was the United States public health surgeon in Milwaukee from 1915 to 1950, when he retired from government service. He was a member of the Medical Society of Milwaukee County, the State Society, the American Medical Association, and the Gastro-Intestinal Society of Milwaukee.

He is survived by his widow, Margaret; two sons, Robert J. and James F.; and three sisters, Miss Ida E. Bach and Mrs. Herman Penner, Milwaukee, and Mrs. A. E. Lasseter, Long Beach, California.

**Dr. Earle E. Kidder**, 56, died on June 4 at Stevens Point. He was born on March 30, 1898, at Whitehall, Wisconsin.

He was graduated from Northwestern University Medical School in 1923 and interned at West Suburban Hospital, Chicago. He practiced at Excelsior, Wisconsin, until 1926, then spent a two-year residency at Methodist Hospital in Madison. Before going to Stevens Point in 1930, Doctor Kidder was in general practice at Hibbing, Minnesota.

In 1942, he enlisted in the Army and served as a captain and major until October 1945. Nine months of that time were spent in Europe.

Doctor Kidder was very active in the State Medical Society, having been a delegate from Portage County Medical Society to the House of Delegates from 1941 until 1942 and from 1946 through 1950, and a member of the Council. He was a former vice-president of the Portage County Medical Society and was secretary of the group from 1936 to 1940. Besides his membership in his county medical society and the State Society, Doctor Kidder was a member of the American Medical Association and the American Academy of General Practice. He served as president of the staff at St. Michael's Hospital from 1949 to 1950.

Surviving Doctor Kidder is his widow, Mabel.

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# WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

## Major Illness Expense Insurance

During the month of July, Wisconsin Physicians Service will begin sale of its newly developed Major Illness Expense Insurance program. This program will be offered to groups of 50 or more employees as a supplement to their basic Blue Shield coverage.

Major Illness Expense Insurance requires the participant to pay a certain amount "out-of-pocket" before benefits begin. This deductible may range from $200 to $500. The policy has a maximum of $5,000 per person per illness.

The following is a summary of the benefits provided by the Major Illness Expense Insurance plan of Wisconsin Physicians Service:

Payments under this plan are predicated on the "customary, usual and reasonable" charges for professional and other services and supplies performed or purchased in the United States and Canada.

PHYSICIANS' SERVICES—Blue Shield Major Illness Expense plan will pay 100 per cent of all reasonable charges for professional services performed and billed by a participating physician and 80 per cent of such charges for services performed and billed by a non-participating physician.

OTHER SERVICES AND SUPPLIES—Blue Shield Major Illness Expense plan will pay 80 per cent of the charges for the following items or services prescribed or recommended by the attending physician, provided charges for these are not made by a hospital:

1. *Special Nursing Care*—Rendered by a nurse, registered, licensed, or certified under the laws of the state in which the services are performed, other than one who ordinarily resides in the subscriber's home, or who is a member of the immediate family, so long as such nurse is under the direction of the attending physician.
2. *Dental Services*—Rendered by a licensed dentist for oral surgery, and for the extraction and replacement of teeth; provided such oral surgery, extraction or replacement is necessitated by an illness for which treatment is being rendered by a physician, and for which benefits are payable under this plan.
3. *Physical Therapy*—Treatment by a physical therapist other than one who ordinarily resides in the subscriber's home or who is a member of the immediate family.
4. *Drugs and Medicines* which, by law, require a written prescription.
5. *X-Ray*—Charges for the use of x-ray equipment, including film.
6. *Laboratory*—Charges for the use of laboratory facilities.
7. *Artificial limbs* and eyes.
8. *Oxygen*, and rental of equipment for the administration of oxygen.
9. *Rental of Radium* and radioactive isotopes.
10. *Rental of iron lung* or other mechanical equipment for the treatment of respiratory complications.
11. *Casts, splints*, trusses, orthopedic braces, and crutches.
12. *Charges for blood* or blood plasma in excess of the charges for the first _____ pints required per illness.
13. *Ambulance Service* — Established ambulance service for transportation to and from a hospital.

The following exclusions apply to the WPS Major Illness Expense coverage:

This plan does not cover charges for services or supplies:

1. Covered by a Workmen's Compensation Act or similar legislation; furnished by the U. S. Veterans Administration; provided by any federal or state agency or local political subdivision when the participant is not liable for the cost; to a participant serving in the armed forces, or rendered as a result of any type of enemy action.
2. For eye examinations for the preparation and fitting of eye glasses, including lenses and frames.
3. Performed primarily for cosmetic or beautifying purposes.
4. Due to pregnancy, except charges necessitated by an ectopic pregnancy.
5. Made by a hospital, public sanitarium, nursing home, convalescent home, or similar institution.

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Basic Principles in General Surgery, Two Weeks, September 20
Breast & Thyroid Surgery, One Week, October 25
Thoracic Surgery, One Week, October 11
Esophageal Surgery, One Week, October 4
General Surgery, Two Weeks, October 4; One Week, October 4
Gallbladder Surgery, Ten Hours, October 25
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OBSTETRICS—General and Surgical Obstetrics, Two Weeks, October 4
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Electrocardiography and Heart Disease, Two Weeks, October 11
Gastroenterology, Two Weeks, October 25
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Clinical Uses of Radio Isotopes, Two Weeks, October 4
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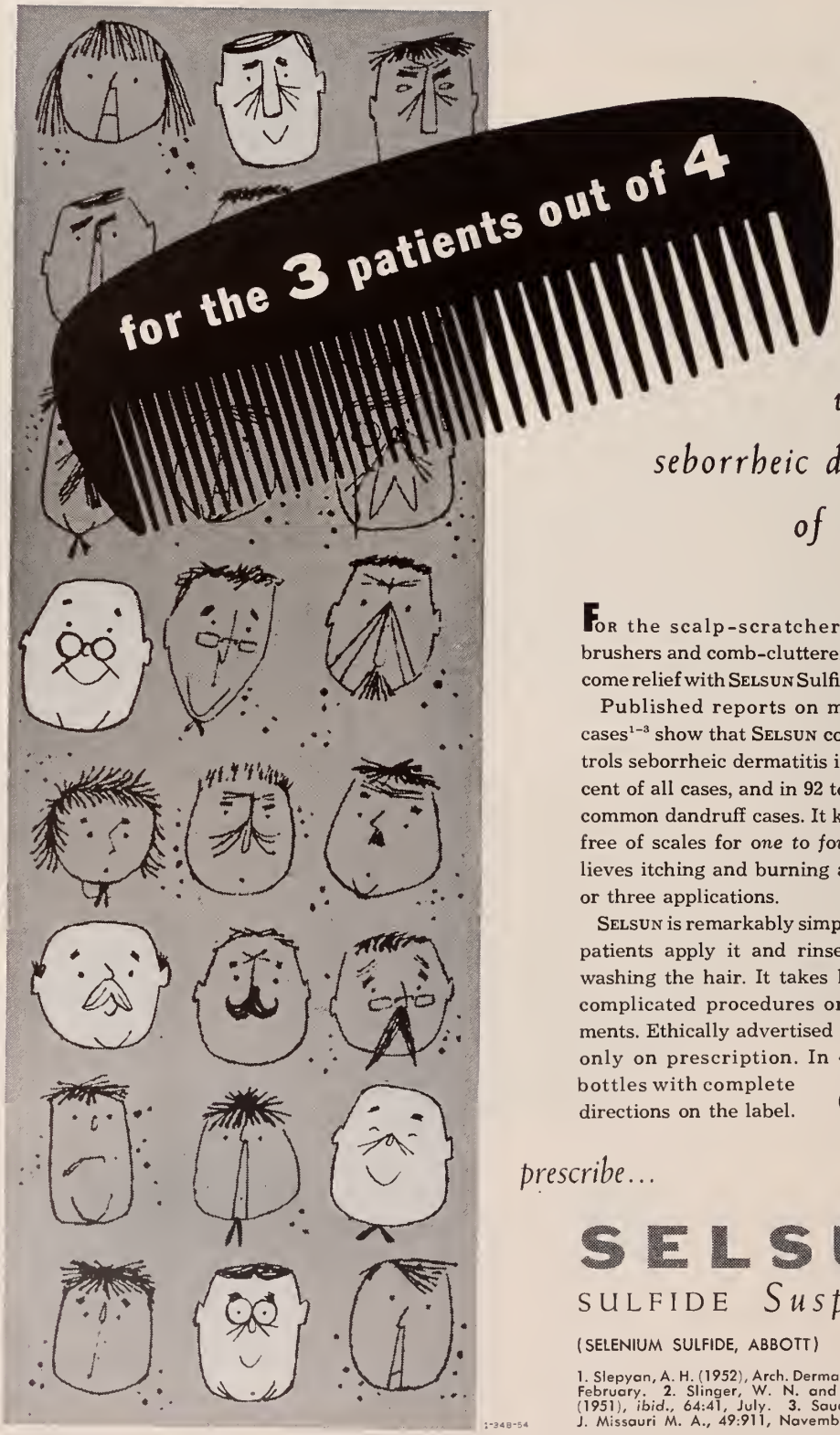


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1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

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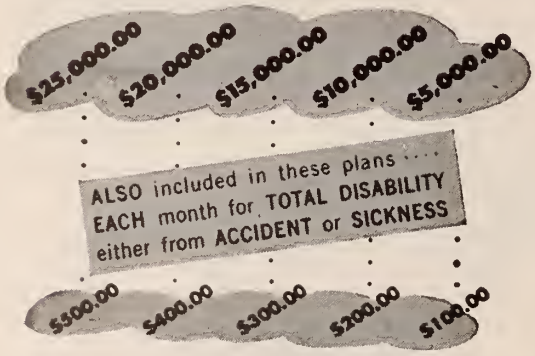


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THE WISCONSIN MEDICAL JOURNAL

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Volume 53 AUGUST 1954 Number 8

# Medical Management of Hypertension With Particular Reference to Hypotensive Drugs*

By JOSEPH H. HAFKENSCHIEL, M. D.**
Philadelphia, Pa.

AFTER it has been found that a patient has arterial hypertension of the idiopathic or essential type, it must be determined whether the symptoms which brought him to his physician are related to the objective findings and whether depressor therapy should be instituted.

Generalizations are difficult, for the guiding principle must be the need of the individual patient. However, it seems desirable to attempt to relieve symptoms. Much can be accomplished by reassurance given during the course of the initial examinations. Depressor therapy should be used in accord with the prognosis.

According to the criteria of Smithwick, it is possible to group individuals into four classes. On medical, or nonsurgical treatment, each class appears to have a different survival experience. Patients in group I have the greatest per cent of survival, about 85 per cent at eight years, whereas in group IV only about 5 to 10 per cent of the patients are still alive at the end of the same follow-up interval. Thus, in a patient in group IV, whose outlook without treatment is not good, drastic depressor therapy may be justified; at the end of a seven-year follow-up interval, it has been found that Smithback's use of bilateral thoracolumbar sympathectomy has improved the survival percentage to only about 35 per cent. Therapy with hypotensive drugs might be expected to prolong the lives of only a few group IV patients. This is because the complications of the hypertensive state which put patients into this group are for the most part irreversible.

Patients who have diastolic pressures persistently over 120 mm. of mercury and systolic pressures around 200 mm. of mercury are candidates for careful study. If they have grade I or grade II hypertensive retinopathy, no cardiac enlargement, a normal electrocardiogram, and a 15-minute excretion of intravenously administered phenolsulfonephthalein (P.S.P.) in the range of 30 to 50 per cent, these patients are in Smithwick group I. If they have no symptoms and if periodic repetition of the base line studies indicates no progression, these patients are often best managed by inducing them to lead a more hygienic life, by combating obesity, and by encouraging a restricted intake of sodium chloride. If the patients have been drinking large amounts of fluids containing caffein, this excess should be stopped. Sedation may be useful if the patient's working efficiency is not impaired by the sedative. We have studied the effect of abstinence from use of tobacco on blood pressure levels and pulse rates in patients on a low salt and low calorie diet, and a majority of patients in group I have shown a reduction in diastolic pressure to top normal levels and also a slowing of the pulse rate. In those patients in group I whose symptoms are not controlled by this program or who show evidence of progression of cardiovascular or renal complications, such as a real and often insidious deterioration in

---

* Presented at the One Hundred and Twelfth Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 7, 1953.

This study has been supported in part by the National Heart Institute (H–361–C4), the Squibb Institute for Medical Research, Eli Lilly and Company, Ciba Pharmaceutical Products, Inc., Burroughs Wellcome and Company, Inc., and the Southeastern Pennsylvania Heart Association.

** Hypertension Section, Robinette Foundation, Medical Clinic, Hospital of the University of Pennsylvania.

renal function, hypotensive drugs should be tried.

Drugs now available that are potent and useful are extracts of Rauwolfia serpentina and of veratrum viride; distinct chemical compounds such as reserpine (Ciba "Serpasil"), hydrazinophthalazine (hydralazine, Ciba "Apresoline"), and protoveratrine (Lilly "Provell," Pitman-Moore "Veralba," and Sandoz "Puroverine"); and hexamethonium salts (Burroughs Wellcome "Hexameton," Squibb "Bistrium," Ciba "Esomid," McNeil "Hesalin," and Warner-Chilcott "Methium").

Our objectives should be to initiate hypotensive therapy before the patient has had any serious impairment of renal, cerebral, or myocardial function. Unfortunately, this is not always possible since many patients have few or no symptoms while their important organ systems are undergoing changes which may have important implications as to survival.

We usually initiate therapy in patients of group I with the most innocuous drug. At this time there seems to be little choice between the very recently introduced Rauwolfia extracts and the long-tried veratrum viride extracts such as "Vergitryl" or "Veriloid." If they are prescribed as experience has indicated, few side actions are encountered.

At the Hospital of the University of Pennsylvania, we have been studying the place of hydralazine in therapy; and I wish to make some comments arising out of a three-and-one-half year experience with about 200 patients.

We initiate therapy with a dose of 10 mg. four times daily and gradually increase the dose over a period of time ranging from weeks to months, depending upon the individual patient's response. The effective oral dose range is from 25 to 200 mg. per dose. There is no evidence of the development of tolerance. If the hypotensive response is not considered satisfactory in the young patients of Smithwick groups I and II who are placed on this compound, the dose is increased slightly at each visit. The drug seems to have its greatest usefulness in the patients in these groups who have severe diastolic hypertension, no angina, and minimal vascular complications.

Hydralazine-treated patients must be carefully observed for further progress of vascular complications, noting such things as increasingly severe retinopathy or greater reduction in the 15-minute P.S.P. excretion. Also, untoward effects of long-continued drug therapy should be sought for in these patients. In a few patients we have observed anemia or an arthralgia picture simulating rheumatoid arthritis; and in one patient a syndrome which resembled lupus erythematosus disseminatus appeared following intense exposure to the sun.

Our results in the first 26 patients of Smithwick I and II groups who have been taking this drug for one year or more showed over 50 per cent having a reduction in blood pressure and 15 per cent having improvement in vascular complications such as retinopathy or factors that cause abnormal electrocardiograms.

We are now studying the extracts of Rauwolfia and what appears to be the active alkaloid of the extracts, reserpine. If this drug can be shown to effect a comparable degree of blood pressure reduction and improvement in vascular complications and proves to have fewer unfavorable early side actions and fewer late toxic manifestations, it may well become the drug of choice for patients with early hypertension. Our experience to date has not enabled us to define the single effective oral dose. Based on intravenous injection studies, it appears as if a dosage of reserpine of 0.07 mg. per kg. of body weight per twenty-four hour period leads to a reduction in mean blood pressure. It appears that several tablets (0.25 mg. Ciba "Serpasil"), given each day to patients of group I with moderate diastolic (110 to 120 mm. of mercury) hypertension, may, in three to eight weeks, bring down the diastolic pressure level to normal or to top normal figures. Some extracts have a more striking effect on slowing heart rate than on reducing the blood pressure. Unpleasant effects that may appear after two to four tablets (Squibb "Raudixin," 100 to 200 mg.; Riker "Rauwiloid," 4 to 8 mg.; and Ciba reserpine "Serpasil," 0.5 to 1.0 mg.) are restlessness or too much sedation; nasal congestion; headache; and epigastric discomfort, with flatulence, diarrhea, and nightmares later. A late effect is a voracious appetite, making for easy gaining of weight. The long-term beneficial and detrimental effects have not been clarified as yet. We believe that the greatest usefulness may be as an adjunct to "Apresoline" or veratrum therapy.

Unfortunately, the narrow range between unpleasant side actions and a satisfactory hypotensive effect has prevented many of our patients from continuing to take veratrum extracts. Our experience with oral protoveratrine has been more encouraging in this regard. This drug is a chemically distinct compound extracted from veratrum album, which active principle can be assayed gravimetrically. It is a very potent drug, the effective single oral dose being in the range of 0.5 to 1.5 mg. This, too, has the narrow range previously mentioned so that when one prescribes an effective depressor dose, the patient may develop salivation, substernal choking and hiccoughing, nausea, vomiting, and peripheral vascular collapse. The patient should know what to expect and be prepared to place a hypodermic tablet of atropine (0.8 mg.) under the tongue at the onset of salivation. The dose should be periodically reduced at least every six to twelve months in order to avoid cumulative untoward effects. We believe that the greatest usefulness of this drug is in patients of Smithwick group IV whose renal damage contraindicates surgery and whose kidney excretory function is good enough so as not to present a syndrome of nausea and vomiting in itself.

Oral hexamethonium has not been as useful in our hands as it would appear to be in England or in the clinic population of the large centers in southern United States. The drug is useful in the management of acute crises in the hospital and probably should not be used orally until the intravenous route has established the individual's tolerance to this compound. We have used this drug orally in outpatients but always start with a small dose (125 mg. after each meal and at bedtime) because extreme caution must be observed to prevent the severe depressor effects of the first dose.

An effective oral dose of hexamethonium, when given before meals, may produce a varying effect in any one patient. There is also great variation in the effects observed in different patients. The dosage range is between 125 and 1,000 mg. Unfortunately, serious side actions make long-term therapy difficult because drug-fastness appears early, and an increasing dose must be prescribed to hold a given depressor effect. When this is done, unpredictable syncopal reactions may be expected. The patients may also suffer from weakness, obstipation, impaired vision, urination difficulties, and impotency (males). I believe that this compound is most useful in short-term oral treatment when combined with other vasodepressor drugs until an effective dose of reserpine ("Serpasil"), "Apresoline," or veratrum is attained. We are studying Pentapyrrolidinium Bitartrate (May and Baker "Ansolysen") to determine whether its advantages over hexamethonium offset the disadvantages.

Finally, it should be pointed out that occasionally patients appear to be having a satisfactory hypotensive response on a depressor drug; but repetition of the initial laboratory studies indicates progression of their cardiovascular or renal damage. An example was a 29-year-old male in Smithwick group I who, despite a lower blood pressure and relief from his headache while on a low salt diet and protoveratrine, showed progression in his cardiac enlargement. Consequently, we recommended a sympathectomy while his renal function was well preserved. The hypotensive response in this patient in the 18 months after operation has been satisfactory. Such a problem illustrates the importance of being prepared to alter the treatment program when indicated. This may mean successive trial of various drugs, alone or in combination, or the institution of surgical procedures if necessary.

It seems clear that the study of measures used to control the abnormal elevation in blood pressure in these patients must do four things: (a) it must define their acceptability; (b) it must show whether they arrest the progression of the vascular complications; (c) it must decide whether they reduce blood pressure; and (d) it must determine their ability to prolong life. This report, then, must be considered a preliminary attempt to evaluate the results of a long-term study program.

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# Etiological Considerations in Arterial Hypertension

## As Determined by the Success of Certain Medical or Surgical Procedures*

By JOSEPH H. HAFKENSCHIEL, M. D.**
Philadelphia, Pa.

INTERRELATIONS in the regulation of blood pressure within normal levels are many and complex. Even more numerous and complex are the interactions in arterial hypertension. On the basis of different types of approaches to the management of patients with arterial hypertension, patients are grouped as those having hypertension secondary to some other disturbance which can be attacked therapeutically in a direct fashion and as those whose hypertension is "primary" or "essential." The latter group is treated empirically in the attempt to minimize the vascular complications that are associated with pathologic elevations of arterial pressure.

Unfortunately, the patients with secondary hypertension comprise only a small group (10 per cent) of the total hypertensive population. Renal disease is responsible for the largest proportion of the cases in this group. Treatment of acute urinary tract infections such as pyelonephritis, discovery of polycystic kidneys, and assessment of the role of unilateral uropathy are important as a part of the daily work of the practitioner. However, the relation of the syndrome of renal infarct to hypertension is not widely appreciated, although it may not be as rare as we now think. Dramatic relief can be afforded by surgical intervention at the appropriate time.

Less prevalent is toxemia of pregnancy, with hypertension probably secondary to a release of a pressor substance into the maternal circulation from either the kidney or the placenta. The effect of the pressor substance on the maternal arterial system can be mitigated by reduction in salt; by use of depressor drugs such as protoveratrine, "Vergitryl" or "Veriloid," and "Apresoline"; or, if necessary, by terminating the pregnancy.

Tumors of the adrenal medulla (pheochromocytomas) may be responsible for either intermittent or sustained hypertension. The clinical picture, laboratory studies, x-rays of the suprarenal area, and more or less specific pharmacologic tests enable one to be suspicious enough of the diagnosis to warrant exploratory laparotomy. In most instances, surgical removal of the tumor is followed by relief of symptoms and a reduction of blood pressure except in those patients where there is another pheochromocytoma elsewhere.

Overactivity of the adrenal cortex, as manifested in Cushing's syndrome, has been controlled by subtotal ablation of the adrenal glands. The results of Sprague and his colleagues suggest that if operation is carried out early enough, the results are more satisfactory than with any other treatment so far advocated for this serious malady. However, no treatment gives results sufficiently good to boast about.

Temporary depression of adrenal cortical function following the prolonged use of cortisone has been reported. If surgical procedures are to be undertaken in patients on cortisone, one should consider carefully the hazard of adrenal cortical insufficiency. Such patients should be treated prophylactically with cortisone in a larger dose given before and after operation. All patients who have had prior therapy with both ACTH and cortisone, whether treated prophylactically or not, should be observed with great care so as to avoid postoperative adrenal cortical insufficiency and secondary shock.

Although many children and most young adults with coarctation of the aorta do not have symptoms, this malformation is not an innocuous affair. It can be diagnosed clinically by demonstrating that (a) the femoral pulse is weak or absent, or (b) the blood pressure in the arms exceeds that in the legs by 20 mm. of mercury. In patients age 20

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*Presented at the One Hundred and Twelfth Annual Meeting of the State Medical Society of Wisconsin, October 7, 1953.

This study has been supported in part by the National Heart Institute (H–361–C4), the Squibb Institute for Medical Research, Eli Lilly and Company, Ciba Pharmaceutical Products, Inc., Burroughs Wellcome and Company, Inc., and the Southeastern Pennsylvania Heart Association.

** Hypertension Section, Robinette Foundation, Medical Clinic, Hospital of the University of Pennsylvania.

and under, surgical repair of the defect is possible, with improvement of the circulation to the lower part of the body and hence relief of the cephalad hypertension and excessive cardiac load. Certain older patients may also have good results from operation, although operation is more hazardous.

In patients with unexplained hypertension, the influences of heredity, abnormal retention of sodium chloride, and excess body weight seem important. The beneficial effects of combined sympathectomy and adrenalectomy in patients with severe essential hypertension, followed for as long as three and a half years after operation, are encouraging enough to warrant continued study.

Hospital of the University of Pennsylvania, 3400 Spruce Street.

## MILWAUKEE ACADEMY OF MEDICINE SPONSORS ESSAY CONTESTS

Two essay contests are being sponsored by the Milwaukee Academy of Medicine again this year—the Horace Manchester Brown Memorial Prize Essay Contest and the Rogers Memorial Prize Essay Contest, the latter founded by the Rogers Memorial Sanitarium of Oconomowoc.

In the Horace Manchester Brown Memorial contest, the Academy offers prizes of $100 and $50 for the two best scientific essays in any field of medicine, surgery, or the allied specialties. The essays need not represent original investigation but should represent individual work and must not have been previously published.

The contest is open to all physicians who have graduated from medical school within the past ten years and are residing in the state of Wisconsin or are in the Armed Forces at the time the essay is submitted. Physicians who have been discharged from the Armed Forces and who have been graduated for more than ten years may submit essays if deduction of their period of service will bring them within the above-mentioned ten-year period after graduation. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays will be read at subsequent meetings.

Prizes of $200 and $100 will be offered in the Rogers Memorial Contest for the two most meritorious studies in the fields of neurology, psychiatry, and psychosomatic medicine. The contest is open to all members of the medical profession who are citizens of the state of Wisconsin, whether they are actually in residency or not, and to those who, though not ordinarily residents of the state, are stationed in Wisconsin in the Armed Forces. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays may be read at subsequent meetings and must be placed on file in the library of the Rogers Memorial Sanitarium, but may be submitted for publication (with proper acknowledgment) at the discretion of the author or the Rogers Memorial Sanitarium.

In both contests, all papers must be double spaced and submitted in triplicate to the office of the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3, Wisconsin, not later than December 1. The committee reserves the right to withhold the awarding of prizes if in its judgment no papers worthy of award have been submitted.

## BOARD OF MEDICAL EXAMINERS ANNOUNCES FALL RECIPROCITY MEETING

October 15 is the date that has been set by the State Board of Medical Examiners for its special fall reciprocity meeting.

The meeting will be conducted on the eleventh floor of the State Office Building, Madison; and the Board will consider applications for license by reciprocity.

# Porphyria and Porphyrin Metabolism*

By JAMES L. JAECK, M. D., and MISS LEE HILLER**
La Crosse

WITHIN the past year we have had two patients with porphyria. This disease must be thought of to be discovered because its clinical features are nonspecific and because *routine* laboratory examinations do not pick up the porphyrins excreted. Laboratory verification is necessary for the diagnosis of porphyria.

One of our patients was a forty-five-year-old woman hospitalized for severe abdominal distress out of proportion to objective findings. She had nine healed surgical scars on her abdomen and a long story to relate for each one. There was questionable scleral icterus and slight persistent elevation of serum bilirubin. Because of the above findings in a psychoneurotic female patient, a Watson-Schwartz test of the urine was ordered and revealed large amounts of porphobilinogen, but no bile or urobilinogen. Subsequent analyses have shown large amounts of urinary coproporphyrin III and classified her porphyria as the acute intermittent type, or porphyria hepatica.

Our other case was a twenty-year-old woman who had her urine examined for porphobilinogen at regular intervals because her thirty-two-year-old brother had a severe form of porphyria hepatica. She consistently had small amounts of porphobilinogen and uroporphyrin in her specimens and was asymptomatic. Her porphyria is the latent type, not the congenital.

It is noteworthy that neither patient had a red or dark urine.

Porphyria is a chronic disorder of pigment metabolism manifest by excessive urinary excretion of uroporphyrin and porphyrin precursors and is often associated with certain clinical manifestations. The metabolic error is thought to be an enzymatic abnormality which prevents normal hemoglobin synthesis and metabolism, resulting in the formation of abnormal pyrroles and in excretion of large amounts of porphyrins or their precursors.

Chemically, the porphyrins are pyrrole pigments or pigment precursors composed of 4 "pyrrole rings" linked by methene bridges (=CH—). Their basic structural formula is that of the synthetic compound, porphin (Fig. 1). The outside carbon atoms are numbered 1 to 8. The methene bridges connecting pyrrole rings are designated $\alpha$, $\beta$, $\gamma$, $\delta$ (Fig. 2). The pyrrole rings themselves are numbered clockwise I to IV.

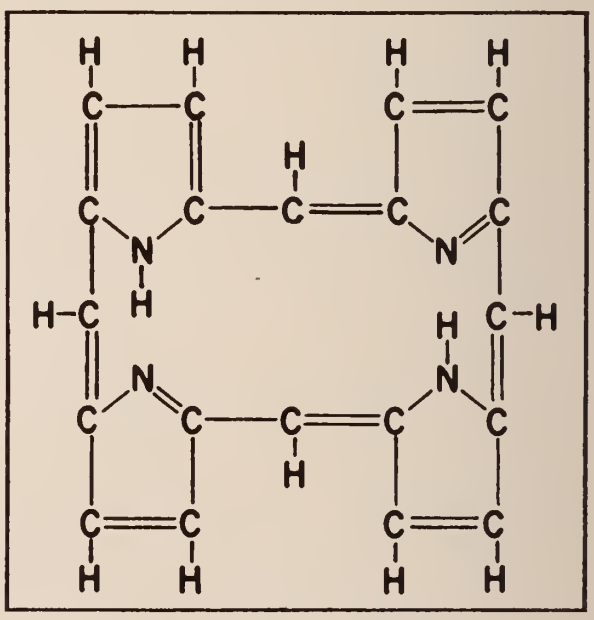

Fig. 1—Basic porphin molecule

The various porphyrin isomers are named according to the number, character, and sequence of the "side chains" replacing the hydrogen on the outside carbon atoms. Fig. 3 shows the skeleton formulae of the clinically important porphyrin isomers. The porphyrin of the hemoglobin molecule, for instance, is protoporphyrin 9, a type III isomer.

The classification of porphyria proposed by Watson[1] is more logical than the older ones because it is based on *organs or tissues responsible* for the overproduction of porphyrins, rather than on purely clinical criteria. Thus, the two classical types of porphyria seem to be either erythropoietic or hepatic in origin.

* Abstracted clinical-laboratory seminar of the Gundersen Clinic, La Crosse. The full-length seminar is available on request.

** Doctor Jaeck is pathologist and director of laboratories, Gundersen Clinic and La Crosse Lutheran Hospital. Miss Hiller is a University of Wisconsin senior medical student (on preceptorship).

I Porphyria *erythropoietica*: (photosensitive or congenital type)
II Porphyria *hepatica*: (acute intermittent type or cutanea tarda or "mixed" type)

*Protoporphyrin*, combined with iron, constitutes the "heme" portion of the hemoglobin molecule and is normally absent from urine. Free protoporphyrin is found normally in red blood cells (15 to 40 gamma per cent). Values are increased in iron deficiency anemias and lead poisoning. Fecal protoporphyrin is increased in hemolytic anemias and in some cases of porphyria.

*Coproporphyrin:* Both type I and III isomers are found normally in urine and feces. In urine the average is 175 gamma per day (70 per cent, type I; 30 per cent, type III). In porphyria, coproporphyrin is excreted in large amounts; in porphyria hepatica, type III, and in porphyria erythropoietica, type I predominates. Schwartz[2] has found coproporphyrin III in trace amounts normally present in erythrocytes. Increases in erythrocyte coproporphyrin III reflect erythropoietic activity of the bone marrow and correlate well with the reticulocyte count of the peripheral blood.

*Uroporphyrin*: This isomer is found *only* in porphyria. In the hepatic type, the so-called Waldenstrom uroporphyrin is found. In erythropoietic porphyria, uroporphyrin I is excreted. In the acute type of porphyria hepatica, uroporphyrin and coproporphyrin are both excreted as zinc complexes.

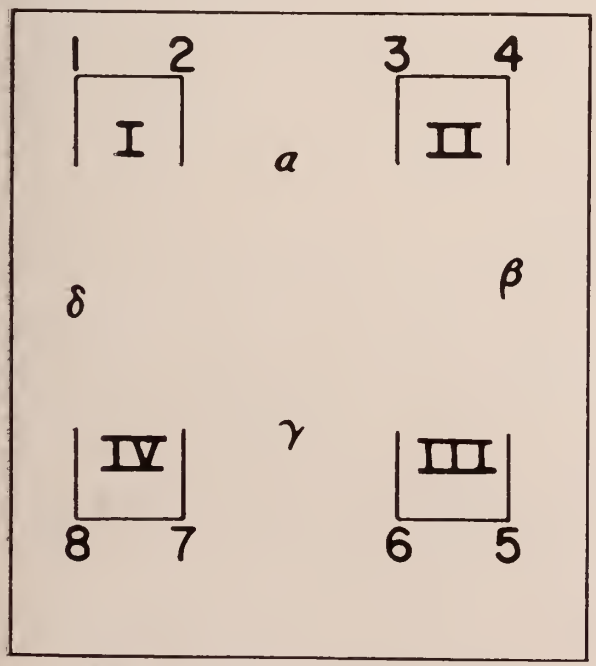


Fig. 2—Nomenclature per basic formula

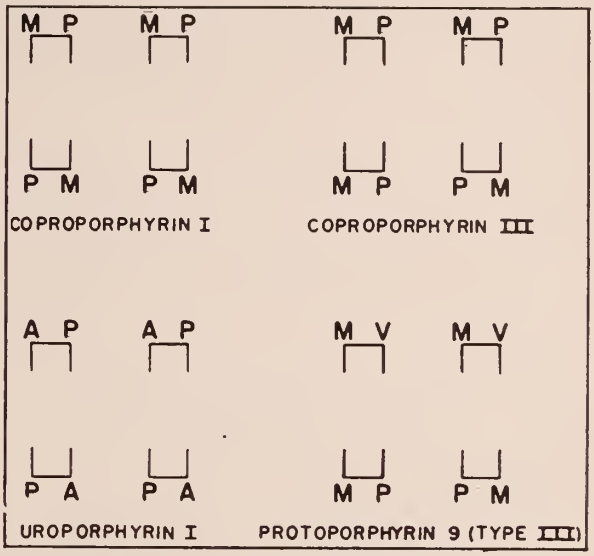


Fig. 3—M = methyl; P = propionic acid; V = vinyl

*Porphobilinogen:* Porphobilinogen is a colorless chromogen and porphyrin-precursor rather than a true porphyrin. It is excreted in large amounts in porphyria hepatica, especially the acute intermittent type. *The demonstration of porphobilinogen in the urine is usually diagnostic of acute intermittent porphyria.* Porphobilinogen is *not* present in the urine in porphyria erythropoietica.

### Laboratory Tests for Porphyria

*Screening test of Watson and Schwartz*[3] *for Porphobilinogen:* This is the first and easiest test to perform and can be done in most any laboratory. It depends on the chloroform insolubility of the *red* Ehrlich porphobilinogen aldehyde.

A fresh urine specimen is important. Mix equal volumes of modified Ehrlich's reagent* and urine to be tested. Add two volumes of saturated aqueous solution sodium acetate. *Positive:* Red color develops when Ehrlich's reagent is added and intensifies on adding sodium acetate. This solution should react red to Congo paper. On shaking with chloroform, the red porphobilinogen aldehyde is insoluble and remains in the aqueous phase. Urobilinogen, which also gives a red aldehyde compound with Ehrlich's reagent, is soluble in and extracted by the chloroform.

* Modified Ehrlich's reagent: 0.7 Gm. p-dimethylaminobenzaldehyde, 150 cc. concentrated HCL, 100 cc. $H_2O$.

Almost no color change is noted from urobilinogen until the sodium acetate is added (not true of porphobilinogen). Both urobilinogen and porphobilinogen *may* be present in the same urine specimen.

*Fluorescence:* All of the free porphyrins show marked fluorescence in ultraviolet light. A positive urine shows red or orange-red fluorescence. In solution, the amount of porphyrin can be quantitated by measuring either the degree of absorption or fluorescence.

*Spectroscopic Examination:* Porphobilinogen has a broad absorption band at 560 to 565 A° and a weaker band at 520 to 525 A°.

Urobilinogen has maximum absorption at 560 to 565 A°.

The zinc complexes of uroporphyrin have two absorption bands of equal intensity at about 538 A° and 578 A°. Addition of equal volumes of 25 per cent HCL gives a strong band at 552 A° and a weak band at 596 A°.

*Quantitative Analysis:* Quantitative methods for porphyrin determination and identification are too involved for the average clinical laboratory. They depend on multiple extractions, progressive decarboxylation, and a good chemistry technician. Zieve[4], however, has recently described a shorter, more simple method for coproporphyrin determination which can be done in the clinical laboratory. This is an important test for both porphyria and lead poisoning.

*Other tests:* Individual porphyrins are further identified by their solubility; their crystalline structure; melting points of their methyl esters; and, more recently, by paper chromatography.

### Clinical Aspects of Porphyria

The acute intermittent type of porphyria hepatica is the most common type encountered clinically. Up to 1951, about 350 cases had been reported in the world.[5] There are probably many times this number that remain undiagnosed. This disease is inherited as a Mendelian dominant trait and is three times more common in women than in men.

The predominant symptoms are abdominal and neurological. Severe abdominal pain, colicky in type and either local or diffuse, is often the presenting complaint.[6] Gastrointestinal symptoms are numerous, variable, and bizarre. Often these patients display multiple abdominal surgical scars as evidence of their plight. The acute attack of porphyria can mimic any acute abdominal condition. Lesser gastrointestinal complaints are present in remissions. Roughly half of the patients with this type of porphyria exhibit psychiatric and neurological manifestations.[7] Some 80 per cent with neurologic involvement die within five years of their first attack. Neurologic symptoms are variable except that sensory involvement is consistently absent. The disease may be confused with poliomyelitis and lead poisoning. Nervous manifestations are often preceded by years of neurasthenia or mild hysteria. Manic-depressive psychosis has been seen. Many patients with this disease are in mental institutions where the true nature of their disease is not apparent until abdominal crises or red urine attract attention. Because of mental symptoms simulating a "toxic psychosis" in some cases and the occasional association of porphyria with lead, alcohol, barbiturate, etc. poisoning, an etiological relationship has been suggested but has never been proved. Menstrual disturbances and hypertension are present in a certain number of patients with porphyria hepatica.

There are no general or routine laboratory tests helpful in the diagnosis of acute intermittent porphyria hepatica. The urine of these patients may be dark red when voided, or it may become red on standing, depending on how much the colorless precursor, porphobilinogen, has been oxidized to the brown porphobilin and depending on how much coproporphyrin and Waldenstrom uroporphyrin are present. *A colorless urine does not rule out the diagnosis.* In the acute phase, the porphobilinogen test of Watson is the most helpful. If this is positive, the urine should be further analyzed for specific porphyrins associated with acute intermittent porphyria. In spontaneous remissions, abnormal pigments may be absent or difficult to demonstrate.

The cutanea tarda type of porphyria hepatica is a relatively benign type found predominantly in males and characterized by bullae of the skin produced by trauma, heat, or visible light;[9] hepatic parenchymal damage;[10] frequent association with alcohol; absence of abdominal and neurological manifestations; and absence of porphobilinogen. These patients excrete either type coproporphyrin or either type uroporphyrin in the urine. This porphyria has been confused with erythropoietic porphyria and even with acute intermittent porphyria.

Porphyria erythropoietica (or congenita) is the rarest of the porphyrias, occurs primarily in male children,[11] presents extensive mutilating skin lesions resultant from photosensitivity, and is frequently associated with hemolytic anemia and splenomegaly. Type I uroporphyrin is excreted in the urine; porphobilinogen is absent. Bone marrow porphyrins are markedly increased and found chiefly in the nuclei of the normoblasts. Splenectomy has been beneficial in this disease.[12] The prognosis is relatively good.

Latent porphyria is the occult porphyria or trait commonly found in relatives of patients with hepatic porphyria. The disease is subclinical, and only weak positive tests for porphobilinogen and uroporphyrin are obtained.

Mixed porphyria occurs in the rare individual who may have cutaneous and abdominal or neurological symptomatology. Porphobilinogen may be present.

### Pathology of Porphyria

There is no specific or diagnostic pathology for porphyria.

### Treatment of Porphyria

In erythropoietic porphyria, splenectomy and avoiding light exposure offer the only hope.

In hepatic porphyria, treatment has been largely symptomatic and ineffective. Barbiturates and morphine should be avoided. ACTH and cortisone[14] have been tried, but psychotic tendencies may be aggravated. In the cutanea tarda type, therapy for the liver damage should be directed toward improved and adequate diet.

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Gundersen Clinic.

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## POLIO VACCINE TRIAL NEEDS PHYSICIANS' AID AS IT MOVES INTO EVALUATION PHASE

More than 600,000 children have completed three inoculations in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The emphasis now shifts to the evaluation study under the direction of Dr. Thomas Francis, Jr., University of Michigan School of Public Health. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, *including those children in the first three grades who did not get vaccine.*

In addition, data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that all cases are completely reported. Early diagnosis, prompt reporting and follow-up, and the securing of *necessary epidemiological information and laboratory specimens* are important factors in the evaluation.

An outline of procedures and copies of necessary forms have been sent to local and state health authorities. It is important that physicians in areas where vaccinations were not given cooperate in the study by notifying local or state health officers of cases occurring among children who participated in the trials and then migrated to another area and children who go to summer camps. Local health officials also need information on participating children who receive injections of gamma globulin.

This phase of the study will depend, to a large degree, on the wholehearted cooperation of practicing physicians.

# Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

## REPORT OF A CASE*

*History:* The patient, a 52-year-old white woman, was admitted to the hospital on October 14, 1953, with the chief complaint of weakness; she had been transferred from another hospital as an emergency. For 2 years she had noted tenderness of the sternum and for 1 year recurrent epistaxis. Two years previously there had occurred spontaneous hemorrhages into the skin of her fingers, and she had had vague flank and abdominal pain for 18 months. In February, 1953, her local physician had noted the presence of albumin in the urine and had treated her for a kidney ailment. At this time an anemia was noted, and the patient was treated with liver injections and capsules. The weakness increased, and in August she developed sharp pain over the sacral area which was aggravated by walking and alleviated by rest. Six weeks prior to admission to this hospital, she had entered another hospital for a one-day period, receiving a blood transfusion at this time. She continued to work around her house and garden; and although her appetite remained good, she tired very easily. Two weeks later the patient received 2 more transfusions; subsequent to this she lost her appetite, and her weakness became progressive and severe. Epistaxis had been almost constant for the 3 weeks immediately prior to her admission. The diagnosis of chronic nephritis was made, and the patient was sent to this hospital for evaluation and treatment. According to both the patient and her husband, she had never had urinary symptoms (no dysuria, polyuria, hematuria, frequency, or urgency). There had been but moderate weight loss, which had occurred in the last few weeks. She had had no fever or sweats.

*Physical Examination:* This examination revealed a well-nourished, well-developed, middle-aged, semistuporous individual who complained of extreme fatigue and desire for rest. She appeared to be very seriously ill, and there was definite pallor. She had intermittent fever during her hospital residence, especially in the terminal period. Ecchymotic areas were present over the sites of previous intravenous injections and on her buttocks. There was no lymphadenopathy. Much clotted blood was present in both nares. There was tenderness over the sternum. The lungs were clear. There was a systolic murmur heard over the precordium, and the blood pressure was 185/109. The liver was 3 to 4 fingerbreadths below the costal margin, but the spleen was not palpable. The extremities showed no edema, and the reflexes were hypoactive.

*Laboratory Examination:* This examination showed 0.7 per cent albumin in the urine but no Bence Jones protein. The blood count was as follows: 8.4 Gm. hemoglobin; 2,190,000 red blood cells; and 6,250 white blood cells, with 22 per cent segmented neutrophils, 15 per cent bands, 1.5 per cent eosinophils, 35 per cent lymphocytes, 9.5 per cent monocytes, 0.5 per cent metamyelocytes, 0.5 per cent myelocytes, 1.0 per cent young mononuclear cells, and 15 per cent atypical cells resembling plasma cells. The blood sugar was 106 mg.; nonprotein nitrogen was 37 mg. per 100 cc. of blood. A blood Wassermann was negative. The carbon dioxide was 25.5, chlorides 104 mEq., sodium 146, and potassium 4.6. A bone marrow study was made. X-ray of the chest showed some enlargement of the heart, with arteriosclerosis of the aorta; there was a marked defect noted in the upper right ribs.

*Course:* During her hospital residence, the patient received 2 blood transfusions. There was progressive decline despite administration of urethane. The bleeding time was prolonged to 23 minutes on October 23, and the patient expired on October 27, 1953.

### Clinical Discussion

**Dr. R. F. Schilling:** Weakness, fatigue epistaxis, ecchymoses, sternal tenderness, and anemia in a woman of 52 years suggest a serious disease such as a blood dyscrasia or metastatic malignancy. The history of slow progression over 20 months is followed

*From the University Hospitals and University of Wisconsin Medical School.

by the development of a sharp pain over the sacrum, and this suggests severe osteoporosis or malignancy involving the bone.

The physical examination is not very helpful. The blood pressure of 185/109 is not considered a feature of the present illness.

The peripheral blood showed a moderately severe anemia and, perhaps of diagnostic significance, 15 per cent atypical cells which resembled plasmacytes.

*Question:* Did the technician notice any rouleaux when the blood was examined?

*Answer:* They were very definitely present.

*Question:* What was the total serum protein and albumin?

*Answer:* The albumin was 1.8, globulin 8.6, and total serum protein 10.4. Anemia, hyperglobulinemia, and pain over a bone suggest multiple myeloma. The bone marrow aspirate is likely to clinch the diagnosis; and the x-rays are probably highly suggestive, if not completely diagnostic.

**Dr. R. L. Baker:** The demonstrated defects in the right upper ribs were suggestive of multiple myeloma.

**Dr. D. M. Angevine:** The significant gross findings at autopsy were large ecchymotic areas in the skin, most marked in the extremities. A recent subconjunctival hemorrhage was noted in the right eye. The heart weighed 390 Gm., and both pericardial and endocardial hemorrhages were present. There were focal subcrepitant areas in both lungs, especially posteriorly and inferiorly. The kidneys weighed 280 Gm. each and were large and pale, with many petechial hemorrhages throughout. The pelves were filled with clotted blood, and there also was some in the upper part of the ureters. Numerous petechial hemorrhages were observed in the small bowel, and numerous elevated ulcers up to 3 mm. across were observed in the colon. The periaortic lymph nodes were hemorrhagic. Numerous rib fractures were present, and they broke readily. The vertebral marrow cut easily, and the bone marrow was pale.

Microscopically, plasma cells almost replaced normal blood forming elements in the bone marrow. The megakaryocytes were reduced. Plasma cells were present in the lung, spleen, liver, kidneys, and lymph nodes.

In the kidney the plasma cells were arranged in nodules. The convoluted tubules were dilated and contained a homogeneous eosinophilic material.

The ulcers in the colon were hemorrhagic and necrotic.

These findings confirm the clinical diagnosis of plasma cell myeloma, and the ulcers are attributed to the effect of antibiotics upon the gastrointestinal flora.

**Dr. K. E. Lemmer:** I wish to emphasize that the lesions of the colon are not due to the toxic action of the drug but are a result of the alteration of the bacterial flora.

**Dr. J. J. Lalich:** Is the absence of pain not unusual?

**Dr. O. O. Meyer:** No.

**Dr. E. S. Gordon:** A serum phosphatase test might have been of help. The level is low in multiple myeloma which is associated with bone atrophy and little or no effort at regeneration.

**Doctor Angevine:** In conclusion, it should be emphasized that although a specialist arrived at the correct diagnosis in this case, nevertheless, on the basis of anemia and albuminuria, this patient was treated as "nephritis" for a period of 2 years before the correct diagnosis was established.

## ANESTHESIA AND ANALGESIA

Physicians attending births can provide valuable information by carefully recording anesthetics and analgesics that were used under Item 29 on the latest birth and fetal-death certificates. This data is being collected and tabulated at the request of the State Medical Society's Division on Maternal and Child Welfare, which is currently undertaking special studies on maternal and fetal-neonatal deaths.

One of the problems encountered has been the reporting of such non-specific items as "General," "Gas," "Routine," "Ob," or just a "V" or "X." Even worse is no entry at all—which could mean the type of anesthetic and analgesic was not indicated or that none was used.

Information gleaned from birth certificates in the past has been valuable to all practicing physicians in Wisconsin. It has broadened knowledge of problems and helped to direct effort toward improved care which has reduced maternal and infant deaths. To be of real value, information collected must be meaningful. We therefore urge all physicians attendant at deliveries to help by entering the *specific* anesthetic and analgesic or "None" if none was used.—ROBERT PURTELL, M. D., *Chairman, Division on Maternal and Child Welfare.*

# Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

## CARDIAC ARREST

Cardiac arrest is one of the most disastrous conditions in medicine. The anesthesia and surgical hazards of the operating room predispose to its development. Safety depends on watchful care and judgment by the surgeon as well as by the administrator of the anesthetic agent. A thorough understanding of the transport system and of the importance of maintaining normal physiologic balance cannot be overemphasized. Immediate correction of even minor disturbances is essential. Anoxia, overdosage of anesthetic drugs, idiosyncrasy to drugs, and abnormal reflex effects cause serious complications. *Prevention* of these by prudent choice of anesthetic agent, judicious care in its administration, and reduction of surgical trauma should be the aim of all concerned.[1]

Through presentation of cases, the Wisconsin Anesthesia Study Commission is directing attention to sources of error. By frank discussion and repetition, it is trying to help physicians profit from the experiences of others.

*Case No. 56*—A 24-year-old white female was admitted to the hospital for a dilatation and curettage after a diagnosis of missed abortion had been made. Her physical condition was excellent. The patient was not seen preoperatively by the anesthesiologist because the case was scheduled late.

She was anesthetized with 350 mg. of 5 per cent sodium pentothal intravenously. 0.43 mg. atropine was mixed with the pentothal. Maintenance of anesthesia was with cyclopropane by to-and-fro absorption technic. An oral airway was inserted when surgical anesthesia was established. During the preliminary examination under anesthesia, the gynecologist felt a mass in the lower abdominal cavity. Dilatation and curettage was done; and since the uterine cavity was clear, she was given 18 mg. of d-tubocurarine intravenously in preparation for an exploratory laparotomy.

There was some respiratory depression with the inhalation of cyclopropane and shortly after the injection of the curare, respiration was assisted by intermittent manual compression of the breathing bag. The anesthetic mixture was changed to nitrous oxide-oxygen (80–20 per cent) by semiclosed technic. Within a few seconds the anesthesiologist noted that the carotid pulse was imperceptible; and although the patient's skin was pink, capillary refilling was absent. The surgeon was notified immediately, and he opened her chest cavity in the fourth left interspace anteriorly. "Mottling" of the skin occurred as the chest was being opened. Simultaneously the patient was intubated by the anesthesiologist, and 100 per cent oxygen was administered by bag and mask under manual positive pressure. The exposed heart was dilated and motionless. Cardiac massage at a rate of 60 beats per minute was done for 45 seconds. Two feeble beats occurred, and massage was continued for 45 seconds more. The heart resumed activity at a rate of 20 beats per minute and then very rapidly increased its rate to 160 beats per minute. It continued beating regularly by its own automaticity. When closure of the chest cavity was finished, the heart rate was regular at 100 beats per minute and blood pressure was good.

The patient was kept in the operating room for a two-hour observation period, during which time 500 cc. of 20 per cent glucose in water was administered intravenously. Oxygen at a rate of 6 liters per minute was given by the oropharyngeal route until she awoke about 12 hours later.

After a 36-hour period of mental haziness, she became lucid on the second postoperative day, with slight transitory memory loss for recent events. On the eighth postoperative day a laparotomy was performed with epidural anesthesia, and an ectopic pregnancy was removed. She was discharged four days later. Three months afterwards no evidence of nervous system damage was apparent.

*Case No. 57*—A construction worker, 34 years old, was admitted to the hospital because of shortness of breath, weakness, and marked exertional dyspnea of four months' duration and cough, chills, and fever for three days.

The patient became afebrile within five days with antibiotic therapy, but he continued to produce large amounts of mucopurulent sputum. Vital capacity and maximum breathing capacity tests showed marked respiratory impairment. Percussion of the chest indicated right ventricular enlargement. Bronchoscopic examination was negative; but because his temperature was again elevated, he prepared for bronchographic studies.

His preoperative medication consisted of 90 mg. of Nembutal given orally two hours prior to the bronchograms, 90 mg. of phenobarbital, and 0.4 mg. of atropine given one hour prior to the diagnostic procedure. The pharynx was anesthetized with a spray of 2 per cent Pontocaine, and additional Pontocaine was introduced through the vocal cords by a catheter. The total amount of Pontocaine used was not recorded. The patient was then transferred to the x-ray department. Approximately five minutes later, he developed mild generalized clonic movements and laryngeal spasm. He was given 450 mg. of Nembutal intravenously, but the laryngeal spasm became more severe and cardiac arrest occurred. Simultaneously, a tracheotomy was performed; and an incision was made between the third and fourth left costal interspaces. Cardiac massage was instituted within three minutes after the pulse became imperceptible.

An anesthesiologist then began artificial respiration through a catheter fitted tightly into the tracheotomy tube. Because of the obvious urgency, he restricted himself to forcing his own breath into the catheter. Later, when proper fitting to an anesthetic machine was made, he utilized 100 per cent oxygen and performed artificial respiration by manual pressure on the breathing bag. Spontaneous cardiac activity returned after massage for five minutes.

The patient was taken to the operating room, where the chest wound was closed. He remained comatose for approximately ten hours and had moderate amnesia for recent events for 48 hours. He is alive and alert and has no residual symptoms one and one-half years after the incident.

### Comment

The cause of cardiac arrest in the first case probably was respiratory depression due to overdose of cyclopropane for the patient. The soda lime canister was efficient. A depressed patient, however, is unable to eliminate carbon dioxide adequately and suffers from a hypercarbia as well as from oxygen want. Lack of oxygen for more than a few minutes is fatal or severely damaging to the organism. Likewise, total blockage of the excretion of carbon dioxide will be fatal in a very short time. Changing anesthetic agents and technic halfway through an operation during a period of respiratory difficulty, like changing horses in midstream, is disastrous. In this instance it resulted in a sudden reduction of inspired oxygen from approximately 70 per cent to 20 per cent and an increase of the oxygen want, the final insult to the heart.

The second patient demonstrated a sensitivity reaction to Pontocaine. Reactions to Pontocaine used topically are not uncommon and frequently follow rapid absorption through a mucous membrane. Because the dosage of the drug given is not known, extreme care must be taken by individuals using a spray. The tendency to use more of the drug than is necessary must be avoided since the limits of safety can be exceeded before one realizes what is taking place.[2] A small amount of the drug correctly applied will produce far more satisfactory anesthesia and be much less hazardous to the patient than large quantities indiscriminately placed. The manufacturer advises that not more than one cc. of a 2 per cent solution or equivalent amounts of other strength solutions be instilled intratracheally. We recommend incorporation of a vasoconstrictor such as one drop of epinephrine, *1 to 50 000* to each cc., to slow the rate of absorption. The use of Nembutal intravenously to control the clonic movements may have increased the oxygen want in the patient who was already in great difficulty with laryngeal spasm. Relaxing agents such as curare or barbiturates should not be given to patients in respiratory difficulty. Keeping the patient well oxygenated is the consideration of first importance. Patients must be observed closely after the use of local anesthetic drugs and probably should not be moved until the danger of occurrence of an untoward reaction has passed.

Cardiac arrest is poorly understood by many surgeons and anesthetists. The majority of individuals are unprepared to handle adequately the situation, and patients are doomed because minutes which cannot be spared are wasted on various diagnostic procedures.[3,4] Every individual who administers any type of anesthetic agent or performs any operation, no matter how minor in scope, must have a definite routine of action established in his mind before this emergency actually presents itself. Radical measures must be begun promptly if the patient is to recover completely. It is known that the maximum time during which circulation may be allowed to be inadequate is between three and three and one-half minutes under the most optimum conditions and in the absence of previous chronic anoxia.[4] The brain will not tolerate asphyxia for a longer period of time or irreversible changes will occur.

The prime requirement in the emergency situation of cardiac arrest is the establishment and maintenance by artificial means of adequate respiration and circulation. The anesthetist usually observes the absence of a palpable pulse and audible blood pressure first, and it should be his duty to direct procedures. Several things should be done almost simultaneously.[5]

1. An accurate note of the time of onset of the emergency should be made.

2. Adequate pulmonary ventilation to permit transfer of oxygen to the tissues and removal of carbon dioxide from the body should be instituted immediately. Direct inflation of the patient's lungs from the operator's own respiratory tract has the advantage of instant availability. A more refined method is the intermittent direct inflation of the lungs by hand pressure on a rubber breathing bag containing 100 per cent oxygen and attached to a face mask or to an artificial airway. When a breathing bag is used, provision for removal of carbon dioxide by soda lime absorption or frequent refilling of the anesthetic bag with fresh oxygen is necessary. The administration of any anesthetic agent must be discontinued and, in situations where the agent was the type that is inhaled, the respiratory tree and the anesthetic apparatus must be cleared of the agent. Carbon dioxide should *not* be added to oxygen used for resuscitation because the patient whose respiration has ceased is already unable to eliminate carbon dioxide retained in his blood and tissues. The patient's airway must be unobstructed, and this can be assured by insertion of an endotracheal tube. Intubation should be done as soon as the equipment to do so in an efficient and rapid, but unhurried, manner is available.

3. The surgeon should be notified of the emergency, and he must act promptly. Artificial circulation must be established immediately. Transabdominal cardiac massage is usually not effective in providing circulation.[6] Direct approach is made through the chest wall by a transverse incision in the fourth left intercostal space, with division of the fourth and fifth costal cartilages. Extensive preparation of the skin, draping of the chest, or waiting for sterilization of instruments have no place in the procedure. Whether the heart is in standstill or ventricular fibrillation, manual rhythmical squeezing of the heart, grasped between the fingers and thumb of a hand, should be started as soon as possible. Compression must be sufficient to produce a palpable peripheral pulse and satisfactory blood pressure and is most effective at a rate of 60 to 80 times per minute. When ventricular fibrillation exists, the recommended treatment is defibrillation. It is important that the heart be massaged prior to any attempt at electrical defibrillation. Momentary shocks of 110 volts alternating current lasting one second or less are sent into the myocardium through two electrodes padded with felt, placed on opposite sides of the heart. If several shocks fail, the heart should be massaged again and serial defibrillation, consisting of a shock of one-third second followed by an interval of one-third second for a total of six to eight shocks, should be attempted. A simple defibrillating device, easily assembled at a reasonable cost, and the technic of its use are described in the literature.[7] After defibrillation, the situation is identical with that of cardiac standstill; and effective cardiac massage must be performed until spontaneous rhythmic contractions resume, or at least for 45 to 60 minutes before abandonment of the case.

In the event of persistent cardiac standstill or feeble contractions, mild stimulants may be used. Two to four cc. of 10 per cent calcium chloride may be injected into the left ventricular cavity during massage. If

sympathomimetic drugs are employed, they should be diluted 10 to 100 times and then given cautiously, at a rate of not more than 2 cc. per minute. The use of *concentrated* doses of analeptic drugs may increase oxygen demand and aggravate the damage from anoxia. After artificial circulation and efficient ventilation have been established, there is time for additional therapy as indicated. General vascular and capillary dilatation follows cardiac arrest and may cause poor venous return. Blood injected rapidly into the auricles in an amount of 500 cc. while the heart is being massaged helps to increase venous return and to increase the cardiac output of oxygenated blood. Intravenous glucose, preferably 10 to 20 per cent, or plasma may also be given.

4. Any situation which has possibly contributed to the emergency, such as the inadvertent addition of an anesthetic agent, recent manipulation by the surgeon which may have precipitated reflex effects, or any position change which was followed by the cardiac arrest, should be corrected.

Adherence to the basic principles of anesthesia; namely, maintenance of a clear airway with adequate respiratory exchange, recognition of the signs of anesthesia, and the avoidance of an overdose of the anesthetic drug, may stop the progression of complications which result in irreversible changes and fatalities. The anesthetists, including individuals who administer local anesthetic drugs, must be in close contact with the patient and be able to recognize changes in balance. "An ounce of prevention is worth a pound of cure."

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## EXHIBIT SPACE AVAILABLE AT WISCONSIN ACADEMY OF GENERAL PRACTICE ASSEMBLY

The Wisconsin Academy of General Practice has announced that it will accept requests from physicians and surgeons wishing to present scientific exhibits at the Academy's Sixth Annual Scientific Assembly, November 30 to December 1 at the Milwaukee Auditorium.

The Academy has reserved approximately ten booths for scientific displays and will furnish the booth, including tables, chairs, and electricity, free to a limited number of applicants. The booths are 10 feet by 10 feet. There will also be commercial exhibitors at the convention.

More than four hundred physicians are expected to attend the two full days of scientific talks, which feature speakers from Harvard and Chicago medical schools, the Mayo Clinic, and various other locations. Last year, three hundred physicians attended a two-day program at the smaller Hotel Schroeder.

Qualified physicians and surgeons interested in presenting scientific exhibits are requested to write for further information to Robert A. Dufour, Executive Secretary, Wisconsin Academy of General Practice, 758 North 27th Street, Milwaukee 8, Wisconsin.

# Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

## Peptic Ulcers and Why Are They?

The writer, as a medical student, had the enviable opportunity of studying gastroenterology under the tutelage of Dr. B. W. Sippy, the originator of the "Sippy routine" or "Sippy diet." It was designed to neutralize or control the acidity of the gastric juice in instances of peptic ulcer and thus relieve the distress and promote healing of the raw surfaces of the ulcer. Much has been learned since that period; and to date the mystery of peptic ulcer, or perhaps one should say, the mystery of absence of ulcers in the majority of people, still exists. One hears a great deal about the ulcer type of personality; but what is there in the personality that predisposes to ulcers, and what is the connection between the mind, personality, and the gastrointestinal tract that makes ulcers possible? Benjamin[1] has said, " . . . the secretion (of gastric juice) is produced by the same hyperactive vagus nerve that causes the vascular changes and that this vascular spasm leads to regional or focal ischemia. Regional ischemia, of necessity, causes anoxia, and only then does the acid cause erosion and ulcer formation."

Necheles[2] quotes Ivy to the effect that the dog does not have ulcers because this creature does not worry about the stock market. Mears[3] reports some interesting and pertinent historical references concerning ulcer which are briefly presented below. As far back as 1853, Virchow emphasized the relation of local vascular disturbances to what is now called ulcer. He contended that ulcer followed hemorrhagic necrosis of the gastrointestinal mucous membrane as caused by disease, obstruction, or spasm of the arteries. Merkel, in 1865, observed ulcers in patients with vascular lesions; and Hauser, in 1883, expressed the view that ulcers are frequently associated with general arteriosclerosis. In 1908, Lewin stated that arteriosclerosis of the stomach may occur even in instances of very slight evidence of atherosclerosis of the aorta or other vessels. Ophüls, in 1913, was so much impressed with the frequency of arteriosclerosis in cases of peptic ulcer that he considered peptic ulcer to be a lesion more or less comparable to that which was antecedent to arteriosclerotic scars in the heart. In 1945, Wangensteen reported that sufficient narrowing or plugging of blood vessels of the stomach or intestine leads to local mucosal ischemia, which in turn leads to erosion by peptic digestion.

The systemic nature of the pathological changes is indicated but not completely established by the observations of Mears. In a series of 168 consecutive cases of coronary occlusion coming to autospy, he observed that thirteen, or 7.7 per cent, had peptic ulcerations. In 116 hypertensive cases, ulcer was found at autopsy in five, a percentage of 4.3.

One may postulate from such observations as cited above that thromboses of blood vessels other than the coronaries and cerebral arteries may also occur, with few dramatic sequelae; but nonetheless they are real. The conception that thrombosis of blood vessels of the stomach or intestines may be basic to ulcer production is an idea that should at least be considered. Coronary thrombosis is generally recognized by its dramatic effects owing to the nature and immediate signs of abnormality of function, whereas signs and symptoms of thrombosis in skeletal muscle, liver, spleen, or even in the gastrointestinal tract, may be entirely unobserved clinically. It is scarcely conceivable that the vessels in these tissues are not as subject to thrombosis as are the vessels of the heart or brain. A few small arterioles in muscles, liver, spleen, or the gastrointestinal tract may be as frequently thrombosed as are the coronaries; yet, being relatively "silent," they are quite unnoticed. Thromboses of the coronary and cerebral arteries, on the other hand, are productive of trouble out of all proportion to simple numbers.

Quite some years ago, Dr. Lester R. Dragstedt reported a very significant experiment, performed by him, on the effect of gastric juice on normal tissue adequately supplied with blood. He placed and fixed the spleen of

a dog halfway into the cavity of the animal's own stomach, carefully conserving the blood supply to the displaced organ. The spleen was not at all digested. Later, Doctor Dragstedt restricted the blood supply to the dog's displaced spleen and soon found that this organ, with its deficient blood supply, did become digested.

The blood supply to the stomach and the intestines is such that it may be practically impossible to produce serious ischemia by ligation of an artery; but when the vessels become thrombosed, possibly subsequent to prolonged spasm, and the channels of collateral blood flow are blocked, the situation may be entirely different, as suggested by the Dragstedt experiment mentioned above.

It has been said by Ivy that ligation of an artery (or even of all of them) to the gastric mucous membrane does not produce ulcers. On the other hand, if all vessels to a localized region be completely and solidly blocked off by thrombosis, no collateral blood supply could possibly suffice to maintain the integrity of tissue in the presence of activated pepsin.

This view of the etiology of peptic ulcers does not indicate, at the present time, any easy, safe, and simple method of treatment other than those already generally employed, which are essentially symptomatic. The therapeutic problem of treatment and prevention of peptic ulcers, therefore, is still unsolved but need not be considered hopeless. Another point of view might reveal new approaches to the problem.—A. L. TATUM, M.D.

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## ANNUAL MEETING, WISCONSIN CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

### October 3, 1954, Schroeder Hotel, Milwaukee, Wisconsin

1:00 P. M. Foyer, Fifth Floor: Scientific Exhibits and Registration

2:00 P. M. East Room: Scientific Program

1. "The Differential Diagnosis of Carcinoma of the Lung," Herman J. Moersch, M. D., Rochester, Minnesota
2. "Management of Cardiac Emergencies," Howard L. Correll, M. D., Milwaukee, Wisconsin
3. "Recent Advances in Inhalation Therapy in Bronchopulmonary Diseases," Edwin R. Levine, M. D., Chicago, Illinois
4. "Benign Tumors of the Chest," William M. Lees, M. D., Chicago, Illinois
5. "Clinical Aspects of Hypertension of the Greater and Lesser Circulation," Charles W. Crumpton, M. D., Madison, Wisconsin

# Grade A Milk For Wisconsin

## As It Looks to Your State Board of Health

TODAY one can go into almost any Wisconsin community and with little difficulty procure a bottle or glass of Grade A milk. The label on it tells a story, a story of ceaseless effort to provide safe, high quality milk by taking every possible precaution.

It was not always so. Back in 1944, Eau Claire was the only Wisconsin city which had adopted the Recommended U. S. Public Health Service Ordinance and Code; and it was just beginning to enforce it. The State Board of Health had also just begun its educational program in milk sanitation and started offering advisory services to local health departments toward development of a sound milk program.

Since that time 53 Wisconsin communities have adopted the Grade A program for the protection of milk supplies. This makes Grade A milk available to more than a million Wisconsin residents besides the tourists who each year visit our wonderful state. The State Department of Agriculture and State Board of Health have also jointly adopted this regulation for all milk sold interstate and intrastate. This gives Wisconsinites access to outside markets which are so vital to our economy. It also gives a small milk dealer who cannot obtain supervision from a health department a chance to have continuous supervision and certification.

The state program works in this way. A small dairy which is not in an area under the supervision of a health department may apply to the Wisconsin State Department of Agriculture. The department, in turn, will assign this dairy a specialized sanitarian, who will give constant supervision. Then, periodically, the State Board of Health will spot check supplies in accordance with the rating procedures of the U. S. Public Health Service. Usually this spot check system is carried out every two years for intrastate supplies and annually for interstate supplies. These spot checks determine the efficiency of enforcement, and reports containing specific recommendations are made to the supervising agency.

Some communities have an organized health department to carry out the administration of a Grade A program using the U. S. P. H. S. Code, qualified personnel, and laboratory services. In this case, the State Board of Health also provides the rating surveys.

The small community needs the same protection as the larger one but often cannot have it because of lack of funds. The State Board of Health has attempted to solve the problem in two ways. It has tried to persuade communities to work together on a cooperative basis by pooling their funds and setting up an administrative milk control board. This board hires and supervises a well-qualified sanitarian, who does the inspection, laboratory, and educational work. This program is exemplified by the Central Wisconsin Milk Control Council, which includes Waupun, Ripon, and Beaver Dam, with headquarters at Beaver Dam, and the Intercity Milk Council (this was the first cooperative control system in Wisconsin), which includes Elkhorn, Lake Geneva, Fontana, Williams Bay, Delavan, Burlington, and Fort Atkinson, with headquarters at Elkhorn.

The second method of control for small communities was proposed by the League of Wisconsin Municipalities; by this method a community can adopt the State Grade A regulations by reference. The local dairies can procure supervision from the State Department of Agriculture. The health officer then requires certification of every dairy selling milk in that community. If a dairy does not have certification from the State Board of Health, it is prohibited from selling milk under the Grade A label. The health officers and physicians can thus be assured that the production, pasteurization, and bottling of milk with the Grade A label have been given adequate supervision.

The development and progress of the Grade A program can be attributed to the interest of all people in a clean, wholesome, safe milk supply. A safe milk supply, designated by the Grade A label, is an integral part of a public health program. We would

like especially to pay tribute to every physician who helped to provide Grade A milk in his community.

Whether the milk is for hospitals, schools, industrial plants, offices, or for the general public, we should remember that the Grade A label represents a milk supply which is produced under clean conditions from healthy herds, is pasteurized in clean, modern plants by skilled operators, is prepared for use under the continuous supervision of an official agency using certified laboratory procedures, and is inspected by well-qualified personnel. These conditions—along with the certification of enforcement procedures—make for Grade A milk, the safest milk available to Wisconsin people.—CLARENCE LUCHTERHAND, *Milk Sanitarian.*

## UNIVERSITY OF MINNESOTA SCHEDULES CONTINUATION COURSES

The University of Minnesota has announced the following continuation courses to be held during September, October, and November. With the exception of the first course listed, all are to be held at the Center for Continuation Study on the University of Minnesota campus.

**September 8–10—Psychiatric Principles in General Practice**

The course will be held at Douglas Lodge, located in the woods of northern Minnesota on the shores of Lake Itasca. The program will concern those psychiatric and psychosomatic problems which are most frequently seen in general practice, and practical management will be emphasized throughout. Sessions will end each day in midafternoon to permit time for fishing, boating, and other recreational activities.

*Guest faculty will include:* Dr. Bernard C. Glueck, Jr., Ossining, New York.

*Under direction of:* Dr. Donald W. Hastings, Professor and Head, Department of Psychiatry and Neurology, and Director, Division of Psychiatry.

*Fee:* $130, which includes registration, tuition, meals and lodging, instructional material, transportation from Minneapolis to Douglas Lodge and return, and fishing license.

*For further information, write:* Director of Continuation Medical Education, University of Minnesota Hospitals, Minneapolis 4, Minnesota.

**October 14–16—The Use of the Minnesota Multiphasic Inventory (MMPI)**

The course is intended primarily for clinical psychologists but will also be open to psychiatrists and other physicians interested in the use of the MMPI.

*Guest faculty will include:* Doctors George Welsh, Associate Professor, Department of Clinical Psychology, University of North Carolina, and Harrison Gough, Assistant Professor, Department of Psychology, University of California.

*Under direction of:* Dr. Starke R. Hathaway, Professor and Director, Division of Clinical Psychology.

**October 28–30—Dermatology for Specialists**

The program will deal with topics of current interest to practicing dermatologists, with special emphasis being placed on sarcoidosis.

*Under direction of:* Dr. Henry E. Michelson, Professor, Department of Medicine, and Director, Division of Dermatology.

**November 4–6—Anesthesiology for General Physicians**

The course will deal with all types of anesthetic technics, including those used in obstetrics. Newer anesthetic agents will be discussed.

*Under direction of:* Dr. Frederick H. Van Bergen, Associate Professor and Acting Director, Division of Anesthesiology.

**November 9–13—Radiology for Specialists**

Bone and Joint Disease will be the subject of the course.

*Guest faculty will include:* Doctors C. Howard Hatcher, Professor of Orthopedic Surgery, University of Chicago School of Medicine; Paul C. Hodges, Professor, Department of Radiology, University of Chicago School of Medicine; John F. Holt, Professor, Department of Radiology, University of Michigan Medical School; G. S. Lodwick, Chief, Department of Radiology, Veterans Administration Hospital, and Clinical Assistant Professor, Department of Radiology, State University of Iowa College of Medicine; Edward E. Neuhauser, Associate Radiologist, Harvard Medical School; and Isidore Snapper, Director of Medicine and Medical Education, Beth-El Hospital, Brooklyn, New York.

*Under direction of:* Dr. Leo G. Rigler, Professor and Head, Department of Radiology.

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# « « « EDITORIAL » » »

## Health Insurance—Business with a Conscience

It is time to take stock in reference to Blue Shield.

The plan provides the opportunity for people in Wisconsin to secure excellent protection against certain costs of illness. Blue Shield continually considers ways and means of making its benefits more comprehensive and extending them to higher limits. Major Illness Expense Insurance is now available from Blue Shield of Wisconsin, a most important development toward better protection.

The possibility of increased premiums is of concern to Blue Shield because of increased utilization, and the deductible feature is considered an approach to this angle.

But making benefits available may be leaving too much undone. The greatest strides Blue Shield has made have been with large groups which are easily insured. The risk is immediately spread. Large groups are much more cognizant of their insurance needs than individuals and, from their advantageous position as a group, can attain them much more readily.

Blue Shield has not shown any pronounced success with the unorganized individuals, often self-employed or employed with but one or two others. Wisconsin is still one-half rural; and, in the rural areas, the unorganized groups predominate. Blue Shield should turn more of its attention to this wide area and, through education, publicity, and personal effort, bring more of these people into the program. From an actuarial basis, these small groups present complications in securing spread of risk, the essence of insurance. By making use of deductible features or waiting periods, perhaps all of them can be insurable risks.

Blue Shield must continually remind itself that its basic philosophy is a professional service to the people of Wisconsin, and business concepts alone are not the complete test of success in this field. Blue Shield has started a strictly non-group enrollment program in the Polk County area for employers of small groups, farmers, and other self-employed people. It is hoped this pattern can be successful enough to expand the program throughout the state or at least to set guideposts for even better enrollment programs for this portion of the population.

# THE MEDICAL FORUM

## STATE SERVES COMPLAINT ON "TUNNEL" OPERATOR

Clients sitting in the "uranium tunnel" in the village of Lone Rock, Richland County.

Madison, August 14.—A complaint has been served on Kenneth Crook, operator of the Lone Rock "uranium tunnel," charging him with practicing medicine without a certificate of registration in the basic sciences.

Crook will have 20 days to answer the charge filed by the Attorney General's office before any further action is taken.

HONECK

**Crook has been operating the "uranium tunnel" since May in the village of Lone Rock in Richland County. He is a 36-year-old farmer.**

Hundreds of persons have been attracted to his "tunnel" every day in search of cures for sickness. His clients pay him a dollar an hour to sit in a room lined with plastic bags filled with what he reports to be low-grade uranium ore. Most of the patrons purchase $10 coupon books which are good for 10 "sittings."

Actually, the "tunnel" is nothing more than a former store building on the main street of Lone Rock. The inside has been partitioned off with pale green wallboard into three rooms.

**Crook has testified that he obtained more than a ton of low-grade uranium ore from Tombstone, Arizona, where there is a similar "tunnel" being used for treating the sick.**

A state official who has tested the ore with a Geiger counter has described its radioactivity as about that of an ordinary radium-dialed wrist watch.

**Leading the investigation of the "tunnel" has been Stewart G. Honeck, Deputy Attorney General for the state of Wisconsin. Some time ago, Crook told Honeck that he was "just doing this to help humanity, if they are getting any good out of it."**

*(Continued on page 450)*

## AMA to Study Medical Practices

Chicago, July 27.—The American Medical Association is going ahead with a pilot study of the controversial issue of unethical practices, including fee splitting (joint billing, methods of payment of an assistant, collection and distribution of fees by a third party, commissions and rebates), and the allied problems of the excessive fees, ghost surgery, and unjustified medical and surgical procedures.

**The work will be conducted through the AMA's Committee on Medical Practices with Dr. Stanley Truman of Oakland, California, as chairman of the 6-member committee.**

This study will be concerned primarily with the underlying reasons for these practices, both psychological and from the socio-economic standpoint.

## Special Committee Studies Role of Clinical Psychologists

Madison, July 9.—The role of the clinical psychologist in medical practice was discussed at a meeting of a special committee on clinical psychologists of the Division on Nervous and Mental Diseases of the State Medical Society.

**Members of the committee who attended the meeting on July 9 were Drs. Hans Reese, Madison; Chester Wade, Milwaukee; Saul Pollack, Milwaukee; and E. D. Schwade, Milwaukee. Dr. Sara Geiger, Milwaukee, was a guest of the committee.**

The committee discussed state laws concerning the licensing or certification of clinical psychologists and the role and utilization of clinical psychologists in medical practice.

## *REHABILITATION CENTER IS BOON TO TB PATIENTS*

Madison, July 15.—The State board of health took time out during its annual meeting at Lake Tomahawk State Camp on July 1, 1954, to make its first visit to one of the local hospitals constructed with the assistance of federal funds under its hospital construction program

**Lakeland Community Hospital at Woodruff, a 16-bed hospital already overcrowded, was proudly shown to the board by its ministering angel, Dr. Kate Newcomb. Dr. Newcomb has recently received national recognition for her life of service to the people in the area on Ralph Edward's, "This Is Your Life" television program**

### Pennies Doubled

As a result the original 1,000,000 pennies contributed locally for construction of the hospital have been more than doubled by those pouring in from all over the country to help this small community finance its new hospital.

The board meets annually at Lake Tomahawk State Camp to see first hand the progress that is being made in training tuberculosis patients sent there by sanatoria after they have progressed sufficiently in their recovery to take on training to prepare them to take their place as self-supporting citizens when they get out.

New drugs and recent developments in chest surgery have cut their recovery time in sanatoria to an average of 18 months, whereas formerly recovery took years for many patients. Training time at the "Camp" has been reduced from an average of 12 to 18 months to 8 months. Lake Tomahawk State Camp currently has 59 patients taking this rehabilitation training.

### Title Change

Because of the confusion caused by the present title of the "Camp," the board is proposing legislation to change the name from Lake Tomahawk State Camp to State Rehabilitation Center.

In further action the board appointed Dr. G. J. Hildebrand, city health officer of Sheboygan, to a three-year term on its Advisory Hospital Council to succeed Dr. E. R. Krumbiegel of Milwaukee, the latter having served with distinction for two three-year terms since the Council was originally established. To represent nursing on the same council it appointed Miss Alice Topzant of Milwaukee County Hospital to succeed Miss Grace Crofts of Madison, deceased, and reappointed Mr. Fred Proctor of Walworth as a representative of agriculture.

In further action the board approved the application of Dr. A. J. Venables, associate director of St. Mary's Hospital Laboratory, Wausau, to perform premarital serology.

Dr. Stephen E. Gavin, Fond du Lac, chairman emeritus of the Council of the State Medical Society, was reelected President of the board, having served as president since 1948. Dr. Samuel Henke, attending dermatologist at Luther Hospital and Sacred Heart Hospital, Eau Claire, was reelected Vice-President, having held this office since 1949.

## Former Wisconsin M.D. Honored in East

Madison, July 25.—Dr. Sarah I. Morris, formerly of the University of Wisconsin, department of student health, has been named the first recipient of the annual Citation of Merit by the Commonwealth Committee of the Woman's Medical College of Pennsylvania.

**Doctor Morris is now director of the division of diagnosis and clinic services of the Bureau of Tuberculosis Control in the Pennsylvania department of health at Harrisburg.**

The award was established to honor those who have made "outstanding contributions to the profession of medicine." During her years as teacher and physician at the University of Wisconsin she reorganized and directed one of the first full-time, four-year required courses in preventive medicine in America and developed one of the first tuberculosis control programs in a medical school.

**The State Board of Health visits Dr. Kate Newcomb and the new Woodruff hospital, latest to be constructed with the aid of Hill-Burton funds. Front left to right: J. S. Hollingsworth, D.D.S., Sheboygan; Stephen Cabana, M.D., Milwaukee; "Dr. Kate"; S. E. Gavin, M.D., Fond du Lac; and Forrester Raine, M.D., Milwaukee. Back left to right: C. D. Neldhold, M.D., Appleton; W. T. Clark, M.D., Janesville; S. L. Henke, M.D., Eau Claire; Frances Cline, M.D., Rhinelander; and C. N. Neupert, M.D., Madison.**

# Stress Emergency Call Services At Public Relations Meetings

Madison, August 15.—Increased emphasis on the development of adequate emergency medical services was called for by the Council on Medical Services at a meeting on August 15.

The Council recalled that it made a detailed survey of emergency medical services available throughout Wisconsin a year ago. From that report, it appeared that most of the people had available to them the means for reaching medical aid in an emergency and that physicians had made reasonable provisions for emergencies in their areas.

Both the profession and the public have a responsibility for the proper functioning of emergency medical services, according to the Council. It outlined several recommendations which will be considered by the Council and the House of Delegates in October.

**Attending the August 15 meeting were Drs. D. E. Dorchester, Sturgeon Bay, chairman; T. D. Elbe, Thiensville; J. F. Maser, Rice Lake; C. G. Reznichek, Madison; and W. J. Fencil, Monroe. Mr. Leo E. Brown, Public Relations Director of the American Medical Association, was a guest of the Council.**

The Council voted to send Dr. R. L. MacCornack, Whitehall, to Chicago to represent the Society at a meeting of the Council on Rural Health of the American Medical Association on September 11. He will meet with the AMA Council and its National Advisory Committee of farm leaders to plan the National Rural Health Conference scheduled for Milwaukee, February 24–25–26, 1955.

The Council completed a detailed study of the importance of safety belts in automobiles and asked that its report be forwarded to the General Council for consideration in October. The American Medical Association meeting in San Francisco in June, 1954, urged the use of safety belts and other safety devices in automobile design and construction.

**The Council voted continued support of the 4–H club health program in Wisconsin. For several years, the Society has made several awards to rural youth as a reward for outstanding personal and community health achievement.**

Appointment of a permanent Committee on Industrial Health was authorized by the Council. The new committee will formulate recommendations for the Society's participation in industrial health programs in Wisconsin.

## "Doctors Talk Too Much About Doctors"

New York, July 27.—Dr. Solomon Krell, chairman of the Board of Censors of the Bronx County (New York) Medical Society, recently announced that his committee had completed a report on 23 complaints against members of that county medical society during 1953–54.

**"It is the opinion of your chairman that a large percentage of the complaints made against the physicians could have been eliminated if the doctor would say less to the patient about fellow physicians and more to the patient about the condition for which he is being treated."**

## Food and Drug Director Retires

Washington, D. C., July 30.—Charles W. Crawford, commissioner of Food and Drugs since 1951, has retired. Mr. Crawford has been in government service for more than 37 years.

In announcing his retirement, Mrs. Hobby, secretary of Health Education and Welfare, said that his "career has been one of outstanding dedication to the work of the Food and Drug Administration, to the federal service, and to the people of the United States."

Under his direction, the department has moved with considerable effectiveness against the producers and distributors of quack healing devices and health nostrums as well as those who engage in spurious types of healing.

Mrs. Hobby also announced that the new commissioner of the Food and Drug Administration will be George P. Larrick, who has been deputy commissioner of the department since June of 1951 and a career employee of the administration since 1923.

## Investigate Federal Role in Health Grants

Washington, D. C., July 25.—A special federal commission has been appointed to investigate the extent to which federal aid should be given to state and local governments in the health field.

**Dr. Franklin D. Murphy, chancellor of the University of Kansas, has been appointed chairman of the study group. Dr. Edward J. McCormick, president of the American Medical Association, is also a member.**

Federal grants in health last year were more than $150,000,000. These were allocated for hospital construction; general public health services in the states; control of certain diseases, such as mental health, heart, cancer, tuberculosis; maternal and child health; and care of crippled children.

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# OSTEOPATHS OKAY AMA VISITS TO SCHOOLS

## Plan Gives AMA Opportunity to Inform Itself

Chicago, August 4.—The House of Delegates of the American Osteopathic Association, meeting in Toronto last July 15, approved on-campus visits of its schools by an AMA committee to determine the quality of medical education provided.

This step dates back to the AMA House of Delegates session in 1952 when a Committee for the Study of Relations Between Osteopathy and Medicine, headed by AMA Past-President John W. Cline, was created. As many doctors know, the Committee did a great deal of work since it was organized.

At the AMA June meeting in San Francisco this year, the Committee submitted "a progress report" to the Board of Trustees, which was later adopted by the House of Delegates.

### AMA Attitude

The Committee's three-page typewritten report said that "the justification or lack of justification of the 'cultist' appellation of modern osteopathic education could be settled with finality and to the satisfaction of most fair-minded individuals by direct on-campus observation and study of osteopathic schools. The Committee, therefore, proposed to the Conference Committee of the American Osteopathic Association that it obtain permission for the Committee for the Study of Relations Between Osteopathy and Medicine to visit schools of osteopathy for this purpose."

Two other important paragraphs of the AMA's Committee report said:

"It was agreed that each school would be visited by two members of the Committee, accompanied by an individual of established experience in inspection of medical schools. The studies would be of sufficient duration, breadth and depth to establish the nature and scope of the educational program and determine the quality of medical education provided.

"The Conference Committee favorably recommended this proposal to the Board of Trustees of the American Osteopathic Association, which considered it at a special meeting on Feb. 6–7, 1954. It has referred the question to the House of Delegates, which will act upon the proposal at its Toronto meeting in July. If the action of the House of Delegates of the American Osteopathic Association be favorable, the on-campus observations can be carried out in the fall of this year."

### AOA Favorable

The action of the House of Delegates of the American Osteopathic Association was favorable. The Association issued a statement last week setting forth the action of its delegates. It is rather lengthy, but since it is so important to our study so far I quote it herewith in full:

"The House of Delegates of the American Osteopathic Association in session in Toronto, July 15, 1954, directed the Conference Committee to continue in its deliberations with the Committee for the Study of Relations Between Osteopathy and Medicine of the American Medical Association.

"In expressing its confidence in the four years' work of the AOA Conference Committee, the House agreed that the Committee should have the authority to negotiate with the AMA Committee on possible visitation by the latter of osteopathic colleges. The purpose of this visitation would be to observe the nature and scope of their education programs. This observational opportunity would be conducted entirely within limits agreed upon by the two committees. The immediate purpose of such on-campus visitations is to provide information to the AMA Committee to assist in its efforts to remove the cultist designation from the osteopathic profession.

### "No Precedent"

"The House of Delegates of the AOA in its approval of such visitations has established no new precedent, except that the proposed visitations would permit a private agency to determine for *itself* osteopathic education programs and procedures. A much wider permission has long been afforded to official state examining agencies, granting agencies of the U. S. Department of Health, Education and Welfare, and other official groups, to visit osteopathic schools. If the AOA Conference Committee permits observation of osteopathic colleges by a private agency—it does so on the basis the American Osteopathic Association has long indicated its willingness to cooperate with the authorized group of any profession, 'wherever that cooperation may be expected to improve the health service offered the public.'

"Approval or accreditation of osteopathic colleges is entirely without the province of observational bodies and any visitations by the Committee on Relations Between Osteopathy and Medicine, if made, will be made purely for the purpose of affording a private agency an opportunity to inform itself about osteopathic educational programs.

### "Mutual Respect"

"In commenting on this action, the newly elected President of the American Osteopathic Association, John W. Mulford, D. O., of Cincinnati, stated that the action was taken by the House of Delegates 'with the complete confidence that neither the osteopathic profession nor the medical profession wishes to inflict its officialdom on the other.' He went on to say that the action of the AOA House of Delegates could be considered as 'a logical outgrowth of the mutual respect which the two schools of healing hold for each other.'"

## New Film List Offered to M.D.'s

Madison, August 10.—A revised catalog of medical and health films now available from the American Medical Association's Committee on Medical Motion Pictures may be obtained on request through the State Medical Society.

This book is brief descriptions of more than 100 films of the type suitable for county medical society meetings. Also included are a number of films suitable for lay audiences.

# Council on Scientific Work Plans May 1955 Annual Meeting

Madison, July 7.—Plans for the May, 1955, annual meeting of the State Medical Society are already under consideration by the Council on Scientific Work.

At a meeting on July 7, Drs. S. A. Morton, Milwaukee; M. G. Rice, Stevens Point; L. G. Kindschi, Monroe; J. S. Hirschboeck, Milwaukee; and W. S. Middleton, Madison, met to discuss details.

The council announced that postgraduate teaching programs are scheduled for the fall of 1954 and will extend through March, 1955. Efforts are being made to locate these meetings in some of the smaller communities within areas where support can be expected. The coming teaching programs will be 2 days in length.

Special attention is being given to the demonstrations and "special interest programs" at the annual meeting for 1955.

Consideration is being given to the establishment of panels on such subjects as steroid therapy, pulmonary surgery, peptic ulcer, hypertension, the anemias, tobacco and causes of death, and selection of patients for heart surgery.

# Urge Special Plan for Patients Unable to Pay

Madison, August 15.—Wisconsin physicians were urged to step up their efforts to assure medical services to everyone in the state regardless of ability to pay.

Mr. Leo E. Brown, Director of Public Relations for the American Medical Association, appeared before the Council on Medical Services to urge follow-up on the AMA House of Delegates resolution of December, 1952, calling for the establishment of programs to provide the services of a physician to anyone unable to pay for medical care.

As a result of the discussions started at the August 15 meeting, the Council on Medical Services will launch an intensive exploration of means to implement the principle that the prime object of the medical profession is to serve humanity regardless of reward or financial gain.

Mr. Brown pointed out that, despite the fact that members of the profession in Wisconsin undoubtedly provide millions of dollars worth of medical care annually without cost to the patient and without remuneration from any other source, the medical profession receives little credit in the eyes of the public for this contribution.

Similarly, the profession is often criticized by implication when publicity is given to individuals who are suffering an unusual or severe affliction and seek public support for money with which to pay physician and hospital bills.

Members of the Council on Medical Services felt that most physicians throughout the state adjust their charges to their patient's ability to pay. There are some instances, however, where the patient's ability to pay goes undetected; and the patient hesitates to mention his financial circumstances to the physician.

The Council felt that it might be to the advantage of the profession to hold open discussions with attorneys, judges, social and welfare workers, and civic, farm, business and labor leaders to explain to them the mechanisms which the profession has set up to deal with these problems.

The Council also urged greater discussion of fees on the part of physicians and patients, a better relationship between the profession and the press concerning the handling of so-called "sympathy" stories, and improved handling of delinquent accounts.

The Council will study these proposals in the future and will also give consideration to the establishment of medical service bureaus or socio-economic services.

D. C. PRESSENTIN

# Pressentin Named Investigator for Medical Examiners

Madison, August 10.—The State Board of Medical Examiners has announced the appointment of Mr. D. C. Pressentin as investigator for the Board.

Mr. Pressentin has a law degree from the University of Wisconsin in 1950 and for a time was employed as a claims investigator for a Madison insurance company. He has recently been conducting his own law practice in Madison.

Mr. Pressentin will investigate complaints of violations of the Medical Practice Act on behalf of the Board. Correspondence regarding investigations may be addressed to Mr. Pressentin at his home address:

5514 Goucher Lane
Madison, Wisconsin

or to the State Board of Medical Examiners, State Office Building, Room 1140, Madison 2, Wisconsin.

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# FAMED NEGRO SURGEON GOT START IN WISCONSIN

By Peg O'Brien

Dr. Daniel Hale Williams, first surgeon to successfully operate on the human heart—an historic event which occurred in Chicago in 1893—was a Janesville barber back in the 1870's. He was a handsome, fair-skinned Negro with red hair. He played bass fiddle in Harry Anderson's Orchestra, which provided the music for early day social functions.

Dr. Williams was a charter member of the American College of Surgeons, along with John B. Murphy, Albert Oshner, the Mayo brothers and John B. Deaver. He was the founder of Provident Hospital in Chicago, the first interracial hospital in the United States. He assisted in the founding of National Negro Medical Association, and he introduced training of Negro interns and nurses and was appointed head of Freedmen's Hospital, Washington, D. C.

### Began as Barber

Why a man of such remarkable achievement was forgotten is told in "Dr. Dan," the inspiring biography written by Helen Buckler, published by Boston–Atlantic-Little, Brown.

Daniel Hale Williams was born in Hollidaysburg, Pennsylvania, January 18, 1856, of German, Scotch, Indian and Negro ancestry. He came from a family of preachers who worked for the Equal Rights League. His father and grandfathers were barbers, and it was as a barber in Edgerton, at the age of 17, that Dan first became known in this area.

### Apprenticed with Doctors

When he came to Janesville to work for Harry Anderson's "tonsorial parlor and bathing rooms," he boarded with the Anderson family on Glen Street. Anderson, a mulatto, had a white wife and five children. The Harry Anderson Orchestra played at the Myers theater as well as dances and wedding receptions. It was Harry Anderson who furnished the funds for Dan's medical education.

In the spring of 1878, Dan became an apprentice in the office of Dr. Henry Palmer, grandfather of Malcolm P. Mouat and Miss Elizabeth Mouat. He swept the office, hitched the doctor's horse, put up "powders" and availed himself of the Palmer medical library.

**With special permission from the author, Peg O'Brien of Janesville, the Section on Medical History of the State Medical Society presents the following account of Dr. Dan Williams, a noted surgeon who spent many of his early days in Wisconsin.**

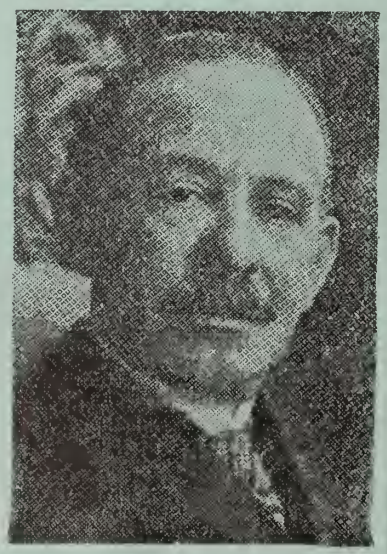
**This is an example of the type of work being done by the Section on Medical History in preserving the record of Wisconsin physicians and their contributions to medical progress.**

**This article first appeared in the *Janesville Gazette* of June 16, 1954.**

### Started Provident

In 1879 Dr. Palmer, who founded Palmer Memorial Hospital that preceded Mercy Hospital, took on two more apprentices, Frank (J. F.) Pember, father of Dr. A. H. Pember, and James Mills, father of Dr. James S. Mills, Cincinnati, Ohio, and Wallace Mills, Rockford. Pember and Mills had attended Milton College for three years.

The three apprentices entered Chicago Medical College, which became Northwestern School of Medicine, in the fall of 1880. At that time, three terms of six months were required for graduation.



DR. DANIEL WILLIAMS

Ordinarily medical students did not intern until their senior year but the first summer in Chicago Dan Williams and Frank Pember worked in the maternity ward of Mercy Hospital, Chicago.

Provident Hospital opened May 4, 1891, with the distinguished Dr. Frank Billings as chief consulting physician.

### "Sewed Up Heart"

It was in Provident Hospital in July, 1893, that Dr Dan operated on the heart of James Cornish, who had been stabbed in a brawl. The patient lived for 20 years after the operation. Another of Dr. Dan's patients, George Cotton, who "had his heart sewed up," lived 50 years.

Dr. Dan developed uncanny diagnostic ability and he did daring Caesarean surgery, such as a triple operation of a dwarf, well advanced in pregnancy, and suturing the spleen. He introduced methods of saving crushed extremities in a day when amputation was the customary procedure. He lectured at Chicago Medical College, held clinics throughout the United States, instituted training schools for colored nurses in the south. He operated at Cook and Mercy hospitals and was on the staff at St. Luke's. His enemies cited outside activities as an excuse to force his resignation from Provident's staff.

### Dr. Dan Vindicated

Severing connection with Provident and the government investigation of his administration at Freedmen's Hospital were blows from which Dr. Williams never recovered. He was vindicated in the investigation of the government hospital, however.

Dr. Dan suffered a stroke and was in retirement for five years at his summer home in Idlewi'd, Mich., where he died Aug. 4, 1931. His funeral was held in St. Aslem's Catholic Church, Chicago, and he was buried in Graceland Cemetery, Chicago.

## COMMITTEE PROPOSES REVISION OF WISCONSIN'S COMMITMENT LAWS

Madison, July 24.—Proposals for comprehensive revision of the Wisconsin laws on the commitment of the mentally ill have been submitted to the State Medical Society's Committee on Public Policy by the Division on Nervous and Mental Diseases of the Commission on State Departments.

Attending a recent meeting of the committee were Drs. E. D. Schwade, Milwaukee, chairman; Owen Clark, Oconomowoc; Keith Keane, Sheboygan; A. A. Lorenz, Eau Claire; J. T. Petersik, Winnebago; Horace K. Tenney, III, Madison; Charles Wunsch, Green Bay; and Walter Urben, Madison.

The proposals still require approval of the Committee on Public Policy and the Council.

The Division on Nervous and Mental Diseases is also considering creation of a special study on alcoholism and publication of a guide for patients in county and mental hospitals.

Doctor Schwade was asked to represent the State Medical Society at a special conference of chairmen of state commissions on mental health being held by the American Medical Association in Chicago on September 17 and 18.

## WATCH FOR BLUE SHIELD ADS

Madison, August 15.—Blue Shield continues to get nationwide promotion in the advertising campaign sponsored jointly by the Blue Shield plans throughout the country.

The latest advertisement for Blue Shield in Saturday Evening Post, Life and Look magazines points out that Blue Shield is paying surgical-medical bills at the rate of $5,000,000 per week.

The ad points out that "Blue Shield is the only non-profit, nationwide organization sponsored by the doctors to help your family meet surgical-medical-maternity expenses."

Physicians are urged to watch for these advertisements in the following issues of the three magazines:

Saturday Evening Post _ August 28
Life Magazine _____ October 4
Look Magazine _____ October 19

## What Patients Kick About

The Kings County, N.Y., Medical Society has turned up some enlightening information in regard to patients' complaints about doctors. After an analysis of the 40 cases handled by the society's Mediation Committee during 1952-53, *the society released the following breakdown of complaints:*

14—Improper diagnosis or treatment.
6—Failure to explain costs.
6—Failure to make call where patient knew doctor.
4—Overcharging.
3—Failure to give reports to patients on their conditions.
2—Failure to treat patient in an emergency.
2—Refusal to treat patient.
2—Not doctor patient thought would treat him.
1—Criticism of other doctor to patient.
1—Failure to follow up on patient's case.
1—Type of bill submitted.
1—Improper exam

These figures reveal one important point—that though some complaints are based on actual medical service rendered by the physician, *the majority of the kicks could be eliminated if each physician practiced sound public relations as well as good medicine.*

Copy in the advertisement reads: "The need for surgery comes without warning—too often it's when you can least afford it. That's why more and more people in communities across the nation are joining Blue Shield. For this organization offers a real protection against unexpected costs of illness.

"Just a few cents a day brings your entire family the maximum Blue Shield protection. Membership fees and benefits are set locally to fit each locality's own needs and conditions."

The ads also explain that Blue Cross is available to provide protection against hospital expenses. It states that Blue Cross provided more than $665,000,000 in care last year.

### THE DOCTOR AND HIS COMMUNITY

Does your community have medical representation at meetings of groups interested in health and welfare? Doctors must help to solve the local problems of the indigent, the aged, and many others. Strict medical care is no longer enough. Free clinics and charity patients are not enough. Some time must be allotted to citizenship.

Doctors must assume community responsibilities on an every day, part-of-the-group basis. The daily and weekly influence of a doctor upon health policies is of the greatest value to a community (such influence cannot be purchased; when you let Joe do it, he does it Joe's way). The medical profession has an obligation to furnish leadership in health matters. Doctors must again become leaders instead of being led.

Lacking time for citizenship
the chance for a solution of problems may be taken from us.

Refusing these responsibilities,
we have no right to criticize foreign and exotic policies of health and welfare groups.

—Quotation from Charles E. Staats, M.D., Chairman, Public Relations Committee, West Virginia State Medical Association

## Special Committee to Study Coroner System

Madison, July 22.—An *ad hoc* committee to study the medical examiner system in Wisconsin has been appointed by the State Medical Society's Committee on Public Policy.

Dr. L. J. Van Hecke, Milwaukee, will serve as chairman. Other members are Drs. Paul Dietz, La Crosse; M. B. Llewellyn, Janesville; and D. Murray Angevine, Madison.

Wisconsin Bar Association studies reveal that the present coroner system is not working satisfactorily as an adjunct in crime prevention. Physicians hope that a change in the existing system will increase the autopsy rate as an aid to medical science.

## State Medical Schools Get Share of AMA Medical Fund

Madison, August 2.—Both Marquette and the University of Wisconsin medical schools have received monies from the first 1954 distribution of unrestricted funds by the National Fund for Medical Education.

**The University of Wisconsin received grants totalling $24,655, and the Marquette University medical school received a total of $28,545.**

All together, the National Fund for Medical Education distributed $2,176,000 to 80 medical schools last July. More than $1,100,000 of this amount was contributed by the medical profession through the American Medical Education Foundation.

Each of the 74 four-year medical schools received $15,000 plus $25 per undergraduate medical student enrolled in the school. Each of the 6 two-year schools received $7,500 plus the $25 per student. Added to these grants were gifts of individual doctors which they had designated be given to the schools.

**Since 1951, nearly $7,000,000 has been awarded to the country's medical schools—half of this total contributed by the medical profession.**

The schools use these funds primarily to fill teaching vacancies, create new faculty posts, and initiate courses in areas of recent scientific advances.

## AMA Film Exposes Quacks

Chicago, August 2.—A new film exposing the quack medical man has been produced by the American Medical Association.

The film, part of which was filmed at American Medical Association headquarters, is the story of how a woman's life is saved by her family doctor after a quack healer is exposed.

This 27-minute film will be available for bookings October 1 through the State Medical Society and can be used for showings on local television stations. Later on the film will be available in a 16-millimeter version for school, church, and club meetings.

## Blue Shield to Sponsor Essay Contest for SAMA

Madison, August 14.—The Blue Shield plans in Wisconsin are participating in a nationwide essay contest for members of the Student American Medical Association at the two medical schools in the state.

**Blue Shield of Wisconsin (Wisconsin Physicians Service) has authorized participation in the contest with the winner from the University of Wisconsin Chapter of the SAMA receiving an all-expense-paid round trip to the Student AMA Annual Convention in Chicago, where he will compete for a national award.**

Surgical Care, the Blue Shield Plan of the Medical Society of Milwaukee County, will conduct the contest for SAMA members at Marquette University medical school.

## Prepaid Plans Committee Prepares 1953–54 Report

Madison, August 14—Details of an annual report to the House of Delegates were discussed by the Executive Committee of the Commission on Prepaid Plans at a meeting in Madison on August 14

**Dr. E. M. Dessloch, Prairie du Chien, Commission chairman, met with Executive Committee members Drs. J. S. Supernaw, Madison; H. E. Kasten, Beloit; and H. Kent Tenney, Madison, to discuss progress during 1953–54 and current and long-range problems of Wisconsin Physicians Service.**

The committee authorized preparation of a Blue Shield exhibit at the Annual Meeting of the State Medical Society in Milwaukee, October 4, 5 and 6.

During the meeting, it was reported that the non-group enrollment program in northwest Wisconsin has been launched, and a stepped-up enrollment campaign will begin September 1. Under the direction of Wisconsin Physicians Service, people in Polk, Barron, Burnett and St. Croix counties are being solicited by representatives of the Granum Agency of Amery for membership in Blue Shield and Blue Cross.

This is the first time in Wisconsin that a private insurance agency has been utilized in the enrollment of Blue Shield and Blue Cross.

## COMPLAINT . . .

*(Continued from page 443)*

Asked about testimonials praising a similar "tunnel" in Tombstone, which are pasted on the front windows of the Lone Rock store building, Crook said that he received the letters in Arizona and that "I took them because they were given to me, but I don't know who pasted them up."

At an adverse examination, Crook maintained that he didn't treat anyone with the radioactive ore in his "tunnel." In fact, he said, he didn't even try to find out what was ailing his customers.

**The complaint charges that the treatment which Crook renders consists of "furnishing, providing, and otherwise making available to his patrons quantities of his so-called 'uranium ore' alleged to have therapeutic qualities."**

**The state's complaint charges that Crook has "openly, publicly, repeatedly, continuously, persistently, and intentionally violated the state laws governing the treatment of the sick by not having applied for and procured a certificate of registration in the basic sciences."**

Reports from Lone Rock since the state has begun its action against Crook indicate that business is going on as usual. Some estimate that, if his operation continues, he will receive as much as $70,000 annually from "tunnel" clients.

The State Medical Society was the first to receive questions and complaints concerning the operation of the "tunnel." The Society reported the matter to the State Board of Medical Examiners, which began action through its legal arm, the Attorney General's office.

### BULLETIN

**The lure of financial success in the "uranium tunnel" business seems to be irresistible.**

**Late reports indicate that James D. Moore, a Sauk County motel operator, plans to open a second "uranium tunnel" as an "exhibit." Moore reports that he isn't breaking any laws because he merely places the ore on display and makes no claims whatsoever as to its curative powers.**

**The Attorney General's office said it wouldn't comment until the matter has been studied.**

# 1954 Annual Meeting

## MILWAUKEE — OCTOBER 4-5-6

## Special Features . . .

**GOLF:** MONDAY, OCT. 4: Ozaukee Country Club. Tee off at 10:00 a. m. Reservations through A. H. Luthmers, Room 700, 208 East Wisconsin Avenue, Milwaukee 2. $9.00 per person, including dinner, green fees, prizes, and entertainment.

**TEACHING DEMONSTRATIONS:**
MONDAY, OCT. 4: 10:00–11:00 a. m., 3:00–3:45 p. m.
TUESDAY, OCT. 5: 9:00–10:00 a. m., 3:00–3:45 p. m.
WEDNESDAY, OCT. 6: 9:00–10:00 a. m.

1. Postanesthesia Recovery Room: Wisconsin Society of Anesthesiologists; James W. Bookhamer, M. D., Milwaukee, and associates.
2. Meeting the Needs of the Amputee: Ray Piaskoski, M. D., and associates, VA Medical Center, Wood
3. The Cranial Cavity (Dissections): Anatomy Dept., University of Wisconsin Medical School, F. D. Geist, M. D., and P. H. Settlage, M. D.
4. OB Manikin Demonstrations (Through Wisconsin Society of Obstetrics and Gynecology)
5. Gross Tissue: Display and discussion by members of the Wisconsin Society of Pathologists.
6. Fracture Demonstrations: By members of Wisconsin Orthopedic Society, under direction of Joseph Stone, M. D., Milwaukee

**DINNER . . . With Floor Show and Dancing:** This will be the final event of the Annual Meeting, on Wednesday, October 6. Following a short "serious program" and the granting of awards to new members of the "50 Year Club," the program will consist of professional entertainment, followed by a dance, until midnight.

**FAMOUS SPEAKERS:** A review of the following pages will show the high quality of the program provided. Speakers from all parts of the country will be featured on the various programs listed.

**FUN!** Ample provision is made for meeting with old friends. Special luncheons and dinners will provide an opportunity for relaxation and renewal of acquaintances. Be sure to plan to attend! Arrange your schedule so you can be in Milwaukee on October 4–5–6!

# Condensed Time Table

## SATURDAY, OCTOBER 2

7:00 p. m.: Interim Committee; Milwaukee Athletic Club

## SUNDAY, OCTOBER 3

12:30 p. m.: Council Meeting; Club Rooms, Hotel Schroeder

## MONDAY, OCTOBER 4

9:00 a. m.: First Session, House of Delegates; East Room, Hotel Schroeder
10:00 a. m.: Golf Tournament; Ozaukee Country Club
10:00 a. m.: Demonstrations; Milwaukee Auditorium
12:15 p. m.: Luncheons; Hotel Schroeder
2:00 p. m.: Reference Committees
2:30 p. m.: General Scientific Assembly; Milwaukee Auditorium
6:30 p. m.: Dinner and Awards; Ozaukee Country Club
7:30 p. m.: Entertainment and Buffet for Delegates and Exhibitors; Blatz Auditorium

## TUESDAY, OCTOBER 5

9:00 a. m.: Teaching Demonstrations; Exhibit Hall, Milwaukee Auditorium
9:00 a. m.: Reference Committees; Hotel Schroeder
10:00 a. m.: Scientific Sessions; Milwaukee Auditorium
(Pediatrics, Internal Medicine, Radiology, and Orthopedics)
12:15 p. m.: Luncheons; Hotel Schroeder
(Marquette Alumni Luncheon at Blatz Auditorium)
2:00 p. m.: Special Program on Anesthesia; Milwaukee Auditorium
2:00 p. m.: General Scientific Assembly; Milwaukee Auditorium
6:00 p. m.: Buffet Dinner, House of Delegates; Hotel Schroeder
7:30 p. m.: Second Session, House of Delegates; Ballroom, Hotel Schroeder

## WEDNESDAY, OCTOBER 6

8:30 a. m.: Third Session, House of Delegates; East Room, Hotel Schroeder
9:00 a. m.: Teaching Demonstrations; Exhibit Hall and Stage, Milwaukee Auditorium
10:00 a. m.: Scientific Programs; Milwaukee Auditorium
(Cardiac and Pulmonary Diseases, Obstetrics and Gynecology, Surgery)
12:15 p. m.: Luncheons; Hotel Schroeder
2:30 p. m.: General Scientific Assembly; Milwaukee Auditorium
5:30 p. m.: President's Reception; East Room, Hotel Schroeder
6:45 p. m.: Annual Dinner, Dance, and Floor Show; Ballroom, Hotel Schroeder

# Auxiliary Time Schedule

MONDAY, OCT. 4: 6:30 p. m.: Board of Directors; Hotel Schroeder
TUESDAY, OCT. 5: 9:00 a. m.: Business Meeting; Pere Marquette Room, Hotel Schroeder
1:00 p. m.: Luncheon; East Room, Hotel Schroeder
WEDNESDAY, OCT. 6: 9:00 a. m.: Business Meeting; Ballroom, Hotel Schroeder
1:00 p. m.: Luncheon and Style Show; Ballroom, Hotel Schroeder

# PROGRAM FEATURES

# MONDAY OCTOBER 4

## *House of Delegates:* HOTEL SCHROEDER

The opening session of the House of Delegates will be held in the East Room, Fifth Floor, Hotel Schroeder, at 9:00 a. m., Monday, October 4. All delegates should be registered prior to the opening of the House. Registration will be in the Fifth Floor foyer of the Hotel Schroeder, and credentials can be checked at that time.

## *Scientific Programs:* MILWAUKEE AUDITORIUM

### 10:00–11:00 a. m.: DEMONSTRATIONS

**Space S–28–29: GROSS TISSUE: Wisconsin Society of Pathologists**

The demonstration consists of gross specimens, fixed and fresh, currently available and of special or general interest. They are drawn from surgical and autopsy cases.

**Space S–33–34: FRACTURE DEMONSTRATIONS: Wisconsin Orthopedic Society**

Special attention will be directed to handling of fractures of the shaft of the humerus by hanging cast method and also fractures of the ankle. Intramedullary nailing of the femur will also be discussed.

**Space S–35–36: THE POSTANESTHESIA RECOVERY ROOM: Wisconsin Society of Anesthesiologists**

This demonstration will be an exhibit of the equipment used in a postanesthesia recovery room and a demonstration and discussion of such equipment. Pictures of recovery rooms in various hospitals will be shown.

**Space S–53–54: THE CRANIAL CAVITY: Department of Anatomy, University of Wisconsin Medical School**

One specimen will show the cranial meninges, cerebral veins, fluid spaces, meningeal vessels, and dural sinuses. A second specimen will present a dorsal view of the brain stem and a complete laminectomy to show the roots of the cranial nerves and their relationships to other structures. The demonstrations are planned primarily for general practitioners confronted with cases of common head injuries.

**Space S–55–56: OB MANIKIN DEMONSTRATIONS: Wisconsin Society of Obstetrics and Gynecology**

Morning Demonstration: "Version Extraction and External Version": L. T. Servis, M. D., Milwaukee

Afternoon Demonstration: "Management of Transverse Presentation and Breech Presentation": Elizabeth A. Steffen, M. D., Racine

**Space S–57–59: MEETING THE NEEDS OF THE AMPUTEE: Ray Piaskoski, M. D., and Associates, VA Medical Center, Wood**

The demonstration will emphasize the teamwork concept of rehabilitation, including the part played by the physician, nurse, physical therapist, limb maker, and vocational counselor. Patients with amputations will be used for demonstrations.

# Monday Oct. 4

■ JOHN ADRIANI, M. D.
New Orleans

■ LEO H. BARTEMEIER, M. D.
Detroit

■ PAUL C. WILLIAMS, M. D.
Dallas, Texas

12:15 p. m.: LUNCHEONS (See opposite page for listings)

2:30 p. m.: GENERAL SCIENTIFIC ASSEMBLY

JUNEAU HALL MILWAUKEE AUDITORIUM

MODERATOR: P. A. Midelfart, M. D., Eau Claire
General Program Chairman for the 1954 Annual Meeting.

2:30 p. m.: **WHAT PATIENTS EXPECT OF THEIR PHYSICIANS**
*(Theresa Rogers Memorial Lecture, Rogers Memorial Sanitarium)*

**Leo H. Bartemeier, M. D., Associate Professor of Psychiatry, Wayne University, Detroit**

3:00 p. m.: **SURGICAL RISKS FROM THE STANDPOINT OF ANESTHESIA**

**John Adriani, M. D., Professor of Surgery, Tulane University School of Medicine, New Orleans**

3:30 p. m.: RECESS TO VIEW EXHIBITS AND DEMONSTRATIONS

DEMONSTRATIONS:

**Gross Tissue:** Wisconsin Society of Pathologists

**The Cranial Cavity:** University of Wisconsin Department of Anatomy

**Meeting the Needs of the Amputee:** VA Medical Center, Wood

**Fractures:** Wisconsin Orthopedic Society

**OB Manikin Demonstration: "Management of Transverse Presentation and Breech Presentation":** Elizabeth A. Steffen, M. D., Racine

**The Postanesthesia Recovery Room:** Wisconsin Society of Anesthesiologists

SCIENTIFIC EXHIBITS:

(See pages 466–468 for complete listing of scientific exhibits)

4:15 p. m.: **LOW BACK PAIN**

**Paul C. Williams, M. D., Clinical Associate Professor of Orthopedic Surgery, Southwestern Medical School of the University of Texas, Dallas**

# ROUND TABLE LUNCHEONS

## *Monday, October 4*

*Note:* All luncheons listed will be held at the Hotel Schroeder from 12:15 until 2:00 p. m. Attendance is limited, so if you have not made your reservations, do so immediately. List three choices in order of preference. (At the time of publication, the luncheon of Dean Middleton is completely filled.) Cost: $2.50 per luncheon. Make your check payable to the State Medical Society of Wisconsin.
If any reservations remain, tickets can be secured in the fifth floor foyer of the Hotel Schroeder at 12:00 noon on the day of the luncheon.

1. LEO H. BARTEMEIER, M. D., Detroit: "Everyday Emotional Problems in Medical Practice"
   Chairman: Owen Clark, M. D., Milwaukee

2. EINAR R. DANIELS, M. D., Milwaukee: "Early Manifestations of Pulmonary Disease"

3. CARL W. EBERBACH, M. D., Milwaukee: "Hyperthyroidism: The Rationale of Modern Treatment"

4. W. S. MIDDLETON, M. D., Madison: "Newer Drugs and Their Uses"

5. JOHN C. PETERSON, M. D., Milwaukee: "General Principles of Fluid and Electrolyte Therapy in Infants and Children"

6. HERBERT W. POHLE, M. D., Milwaukee: "The Management of Hypertension"

7. GEORGE L. THOMAS, M. D., Janesville: "Fractures of the Os Calcis"

8. HERMAN H. SHAPIRO, M. D., Madison: "Home Management of Congestive Heart Failure"

9. W. D. STOVALL, M. D., Madison: "Viruses in Wisconsin: Their Recognition and Control by Immunization"

★

### *Special Luncheon*

10. PAST PRESIDENTS' LUNCHEON:
    All past presidents of the State Medical Society, the current president, and the current president-elect are to attend this luncheon.

★ ★

## *Special Entertainment:* DELEGATES AND EXHIBITORS

All delegates (with their wives) and exhibitors are to be entertained at the Blatz Brewing Company Auditorium at 7:30 to 10:00 p. m. on Monday, October 4. Following a program of music and light entertainment, a buffet supper will be served at 9:30 p. m. Because of limited facilities, only delegates and exhibitors can be accommodated.

# PROGRAM FEATURES

# TUESDAY OCTOBER 5

## *House of Delegates:* HOTEL SCHROEDER

In order to permit all members in attendance at the Annual Meeting to view the deliberations of the House of Delegates and hear the policy determinations made by House action, the second session of the House will be held in the ballroom of the Hotel Schroeder at 7:30 p. m. on Tuesday, October 5. Members of the Woman's Auxiliary, as well as physician members, are urged to attend.

## *Scientific Programs:* MILWAUKEE AUDITORIUM

### 9:00–10:00 a. m.: DEMONSTRATIONS

Space S–28–29: **GROSS TISSUE: Wisconsin Society of Pathologists**
The demonstration consists of gross specimens, fixed and fresh, currently available and of special or general interest. They are drawn from surgical and autopsy cases.

Space S–33–34: **FRACTURE DEMONSTRATIONS: Wisconsin Orthopedic Society**
Special attention will be directed to handling of fractures of the shaft of the humerus by hanging cast method and also fractures of the ankle. Intramedullary nailing of the femur will also be discussed.

Space S–35–36: **THE POSTANESTHESIA RECOVERY ROOM: Wisconsin Society of Anesthesiologists**
This demonstration will be an exhibit of the equipment used in a postanesthesia recovery room and a demonstration and discussion of such equipment. Pictures of recovery rooms in various hospitals will be shown.

Space S–53–54: **THE CRANIAL CAVITY: Department of Anatomy, University of Wisconsin Medical School**
One specimen will show the cranial meninges, cerebral veins, fluid spaces, meningeal vessels, and dural sinuses. A second specimen will present a dorsal view of the brain stem and a complete laminectomy to show the roots of the cranial nerves and their relationships to other structures. The demonstrations are planned primarily for general practitioners confronted with cases of common head injuries.

Space S–55–56: **OB MANIKIN DEMONSTRATIONS: Wisconsin Society of Obstetrics and Gynecology**
Morning Demonstration: "Version Extraction and External Version": David J. Werner, M. D., Milwaukee

Afternoon Demonstration: "Management of Transverse Presentation and Breech Presentation": S. D. Austin, M. D., Green Bay

Space S–57–59: **MEETING THE NEEDS OF THE AMPUTEE: Ray Piaskoski, M. D., and Associates, VA Medical Center, Wood**
The demonstration will emphasize the teamwork concept of rehabilitation, including the part played by the physician, nurse, physical therapist, limb maker, and vocational counselor. Patients with amputations will be used for demonstrations.

### 10:00–11:30 a. m.: SPECIAL INTEREST PROGRAMS (See pages 457–458 for details)
PEDIATRICS . . . INTERNAL MEDICINE . . . RADIOLOGY . . . ORTHOPEDICS

### 12:15 p. m.: LUNCHEONS (See page 459 for details)

### 2:00 p. m.: GENERAL SCIENTIFIC ASSEMBLY: MILWAUKEE AUDITORIUM (See page 460)

### 2:30 p. m.: SPECIAL PROGRAM ON ANESTHESIA (See page 460)

*Tuesday*
*Oct. 5*

# ★ SPECIAL INTEREST PROGRAMS ★

*Note:* While the programs listed are in specialized fields, any members of the State Medical Society interested in the topics presented are urged to attend. Where business meetings of specialty groups are indicated, members of such societies are urged to remain after the scientific program has concluded.

■ ROBERT B. LAWSON, M. D.
Miami, Florida

## *Pediatrics*

WALKER HALL
MILWAUKEE AUDITORIUM

Moderator: E. H. Pawsat, M. D., Fond du Lac

■ ALBERT SCHROEDER, M. D.
Minneapolis

10:00 a. m.: THE TREATMENT OF VIRAL RESPIRATORY INFECTIONS
Robert B. Lawson, M. D., Professor of Pediatrics and Chairman of the Department of Pediatrics, University of Miami School of Medicine, Miami

10:45 a. m.: INFECTIOUS CROUP
Albert J. Schroeder, M. D., Clinical Instructor in Pediatrics, University of Minnesota Medical School, Minneapolis

(At the conclusion of the scientific meeting, there will be a short business meeting of the Wisconsin Chapter of the American Academy of Pediatrics)

## *Internal Medicine*

JUNEAU HALL, MILWAUKEE AUDITORIUM

Moderator: Herbert W. Pohle, M. D., Milwaukee

10:00 a. m.: THE GENERAL ADAPTATION SYNDROME
Hans Selye, M. D., Professor and Director of the Institute of Experimental Medicine and Surgery, Universite de Montreal, Montreal, Canada

10:45 a. m.: PAIN IN THE CHEST
*(The Lucy Ann Droessel Memorial Lecture, Wisconsin Heart Association)*
William B. Bean, M. D., Professor of Internal Medicine, State University College of Medicine, Iowa City

■ HANS SELYE, M. D.
Montreal, Canada

# Tuesday Oct. 5

■ DAVID G. PUGH, M. D.
Rochester, Minnesota

## Radiology

NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM

Moderator: W. T. Clark, M. D., Janesville

10:00 a. m.: SIMPLE BONE CYSTS, ANEURYSMAL BONE CYSTS, AND GIANT CELL TUMORS
David G. Pugh, M. D., Assistant Professor of Radiology, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minnesota

10:45 a. m.: CASE PRESENTATIONS BY WISCONSIN RADIOLOGISTS
(Following the scientific program, there will be a short business meeting of the Wisconsin Radiological Society)

■ W. BRANDON MACOMBER, M. D.
Albany, New York

## Orthopedics

SOUTH KILBOURN HALL
MILWAUKEE AUDITORIUM

Moderator: Charles H. Ihle, M. D., Eau Claire

■ PAUL C. WILLIAMS, M. D.
Dallas, Texas

10:00 a. m.: THE CERVICAL SPINE
Paul C. Williams, M. D., Clinical Associate Professor of Orthopedic Surgery, Southwestern Medical School of the University of Texas, Dallas

10:45 a. m.: TREATMENT AND PREVENTION OF LATE CONTRACTURES OF THE HAND
W. Brandon Macomber, M. D., Associate Professor of Plastic and Reconstructive Surgery, Albany Medical College, Albany, New York

# ROUND TABLE LUNCHEONS

## *Tuesday, October 5*

*Note:* All luncheons listed will be held at the Hotel Schroeder from 12:15 until *1:30* p. m. Attendance is limited, so if you have not made your reservations, do so immediately. List three choices in order of preference. (At the time of publication, the luncheon of Doctor Selye is completely filled.) Cost: $2.50 per luncheon. Make your check payable to the State Medical Society of Wisconsin.

If any reservations remain, tickets can be secured in the fifth floor foyer of the Hotel Schroeder at 12:00 noon on the day of the luncheon.

1. JOHN ADRIANI, M. D., New Orleans: **"Obstetrical Anesthesia and Analgesia"**
   Chairman: L. F. Thurwachter, M. D., Milwaukee
2. WILLIAM B. BEAN, M. D., Iowa City: **"Clinical Vagaries of Myocardial Infarction"**
   Chairman: Francis Rosenbaum, M. D., Milwaukee
3. HARRY BECKMAN, M. D., Milwaukee: **"Recent Pharmacologic Developments of Clinical Interest"**
4. CHARLES W. CRUMPTON, M. D., Madison: **"Clinical Evaluation and Medical Treatment of the Hypertensive Patient"**
5. ALBERT FAULCONER, M. D., Rochester, Minnesota: **"What Is the Meaning of 'Depth of Anesthesia'?"**
   Chairman: W. H. Dornette, M. D., Madison
6. FRED W. FITZ, M. D., Chicago: **"Bedside Diagnosis and Treatment of Cardiac Arrhythmia"**
   Chairman: Lamont R. Schweiger, M. D., Milwaukee
7. ROBERT B. LAWSON, M. D., Miami, Florida: **"Antibiotic Therapy in Pediatric Practice"**
   Chairman: L. M. Simonson, M. D., Sheboygan
8. W. BRANDON MACOMBER, M. D., Albany, New York: **"The Treatment of Lower Leg Soft Tissue Deformities"**
   Chairman: Christopher R. Dix, M. D., Milwaukee
9. ALBERT J. SCHROEDER, M. D., Minneapolis: **"Erythroblastosis"**
   Chairman: Horace K. Tenney, M. D., Madison
10. DAVID G. PUGH, M. D., Rochester, Minnesota: **"Osteomalacia and Osteoporosis"**
    Chairman: S. A. Morton, M. D., Milwaukee
11. JAMES C. SARGENT, M. D., Milwaukee: **"Prostatism in Elderly Men"**
12. HANS SELYE, M. D., Montreal, Canada: **"The Use and Abuse of Cortisone and Allied Hormones in Clinical Medicine"**
    Chairman: A. W. Hilker, M. D., Eau Claire
13. PAUL C. WILLIAMS, M. D., Dallas, Texas: **"Choosing the Candidate for Lumbosacral Surgery"**
    Chairman: Herman W. Wirka, M. D., Madison

### *Special Luncheon*

Marquette Alumni Luncheon: Blatz Auditorium. (Do not make reservations for this luncheon through the State Medical Society but rather by writing Mr. Ray Pfau at the Marquette Alumni Association office, 1533 W. Wisconsin Avenue, or by phoning Mr. Pfau through Division 4–1000, Milwaukee)

### *Remember the Annual Dinner!*

When making reservations for luncheons, remember the Annual Dinner, which will be held on Wednesday, October 6, as the concluding feature of the program. See page 465 for details. Cost: $6.50 per person, including dinner, entertainment, and the dance. Attendance is limited, so make your reservations early.

# Tuesday Oct. 5

**2:00 p. m.: SECTION ON MEDICAL HISTORY: Pere Marquette Room, Hotel Schroeder**

Don McNeil, assistant director of the Wisconsin State Historical Society, will be the speaker. All members are urged to attend. The meeting will be under the direction of W. D. Stovall, M. D., chairman of the Section on Medical History.

**2:00 p. m.: GENERAL SCIENTIFIC ASSEMBLY: Juneau Hall, Milwaukee Auditorium**

MODERATOR: S. A. Morton, M. D., Milwaukee

2:00 p. m.: RECENT PROGRESS IN THE STUDY OF DISEASES OF ADAPTATION
Hans Selye, M. D., Montreal, Canada

2:30 p. m.: TREATMENT IN INFANCY AND CHILDHOOD
Robert B. Lawson, M. D., Miami, Florida

**3:00 p. m.: RECESS TO ATTEND DEMONSTRATIONS AND VIEW EXHIBITS**

DEMONSTRATIONS:

**Gross Tissue:** Wisconsin Society of Pathologists
**The Cranial Cavity:** University of Wisconsin Department of Anatomy
**Meeting the Needs of the Amputee:** VA Medical Center, Wood
**Fractures:** Wisconsin Orthopedic Society
**OB Manikin Demonstration: "Management of Transverse Presentation and Breech Presentation":** S. D. Austin, M. D., Green Bay
**The Postanesthesia Recovery Room:** Wisconsin Society of Anesthesiologists

SCIENTIFIC EXHIBITS
(See pages 466–468 for complete listing of scientific exhibits)

3:45 p. m.: THE TREATMENT OF MALIGNANCIES IN THE SPECIALTY OF PLASTIC SURGERY
W. Brandon Macomber, M. D., Albany, New York

4:15 p. m.: THE DOCTOR AND *HIS* HEART
Frederick W. Fitz, M. D., Chicago

## SPECIAL INTEREST PROGRAM

■ JOHN ADRIANI, M. D.
New Orleans

### Anesthesia

**SOUTH KILBOURN HALL**
**MILWAUKEE AUDITORIUM**

Moderator: L. F. Thurwachter, M. D., Milwaukee

■ ALBERT FAULCONER, M. D.
Rochester, Minnesota

2:00 p. m.: SILENT REGURGITATION AND ASPIRATION DURING ANESTHESIA
John Adriani, M. D., New Orleans

2:30 p. m.: ANESTHESIA EMERGENCIES THAT CONFRONT THE GENERAL SURGEON
Allen E. Talbot, M. D., Appleton

**3:00 p. m.: RECESS TO ATTEND DEMONSTRATIONS AND VIEW EXHIBITS**

3:45 p. m.: CARBON DIOXIDE GAS EXCHANGE IN THE BODY
Albert Faulconer, M. D., Head of Section of Anesthesiology, Mayo Clinic, Rochester, Minnesota

# PROGRAM FEATURES

# WEDNESDAY OCTOBER 6

## *House of Delegates:* HOTEL SCHROEDER

The third and final session of the House of Delegates will be held in the East Room, Fifth Floor, Hotel Schroeder, at 8:30 a. m.

## *Scientific Programs:* MILWAUKEE AUDITORIUM

### 9:00–10:00 a. m.: DEMONSTRATIONS

**Space S–28–29: GROSS TISSUE: Wisconsin Society of Pathologists**
The demonstration consists of gross specimens, fixed and fresh, currently available and of special or general interest. They are drawn from surgical and autopsy cases.

**Space S–33–34: FRACTURE DEMONSTRATIONS: Wisconsin Orthopedic Society**
Special attention will be directed to handling of fractures of the shaft of the humerus by hanging cast method and also fractures of the ankle. Intramedullary nailing of the femur will also be discussed.

**Space S–35–36: THE POSTANESTHESIA RECOVERY ROOM: Wisconsin Society of Anesthesiologists**
This demonstration will be an exhibit of the equipment used in a postanesthesia recovery room and a demonstration and discussion of such equipment. Pictures of recovery rooms in various hospitals will be shown.

**Space S–53–54: THE CRANIAL CAVITY: Department of Anatomy, University of Wisconsin Medical School**
One specimen will show the cranial meninges, cerebral veins, fluid spaces, meningeal vessels, and dural sinuses. A second specimen will present a dorsal view of the brain stem and a complete laminectomy to show the roots of the cranial nerves and their relationships to other structures. The demonstrations are planned primarily for general practitioners confronted with cases of common head injuries.

**Space S–55–56: OB MANIKIN DEMONSTRATIONS: Wisconsin Society of Obstetrics and Gynecology**
Morning Demonstration: "Manual and Forceps Rotation of the Occiput Transverse and Occiput Posterior Presentations and Positions": Russell Lewis, M. D., Marshfield

**Space S–57–59: MEETING THE NEEDS OF THE AMPUTEE: Ray Piaskoski, M. D., and Associates, VA Medical Center, Wood**
The demonstration will emphasize the teamwork concept of rehabilitation, including the part played by the physician, nurse, physical therapist, limb maker, and vocational counselor. Patients with amputations will be used for demonstrations.

**(No afternoon demonstrations as all exhibits down at 3:00 p. m.)**

### 10:00–11:30 a. m.: SPECIAL INTEREST PROGRAMS (See pages 462–463 for details)

OB & GYN . . . CARDIAC AND PULMONARY DISEASES . . . SURGERY

### 12:15 p. m.: LUNCHEONS: Hotel Schroeder (See page 464 for details)

### 2:30 p. m.: CLOSING SCIENTIFIC ASSEMBLY: Milwaukee Auditorium (See page 464 for details)

### 6:45 p. m.: ANNUAL DINNER: Hotel Schroeder

*Wednesday*
*Oct. 6*

# ★ SPECIAL INTEREST PROGRAMS ★

*Note:* While the programs listed are in specialized fields, any members of the State Medical Society interested in the topics presented are urged to attend. Where business meetings of specialty groups are indicated, members of such societies are urged to remain after the scientific program has concluded.

■ HOWARD J. TATUM, M. D.
New Orleans

## *Obstetrics and Gynecology*

JUNEAU HALL
MILWAUKEE AUDITORIUM

Moderator: W. V. Luetke, M. D., Madison

■ JOHN I. BREWER, M. D.
Chicago

10:00 a. m.: THE USES AND ABUSES OF OXYTOCICS IN OBSTETRICS
Howard J. Tatum, M. D., Associate Professor of Obstetrics and Gynecology, Louisiana State University Medical School, New Orleans

10:45 a. m.: CONSERVATISM OF THE OVARY
John I. Brewer, M. D., Professor of Obstetrics and Gynecology, Northwestern University School of Medicine, Chicago

(Following the conclusion of the scientific program, there will be a short business meeting of the Wisconsin Society of Obstetrics and Gynecology)

■ CHARLES CAMERON, M. D.
New York

## *Cardiac and Pulmonary Diseases*

WALKER HALL
MILWAUKEE AUDITORIUM

Moderator: Paul Hausmann, M. D., Milwaukee

■ THOMAS J. E. O'NEILL, M. D.
Philadelphia

10:00 a. m.: EPIDEMIOLOGIC AND LABORATORY EVIDENCE OF CAUSES OF LUNG CANCER
*(Lecture sponsored by Milwaukee and Wisconsin Divisions of The American Cancer Society)*
Charles S. Cameron, M. D., Medical and Scientific Director of The American Cancer Society, New York City

10:45 a. m.: INDICATIONS FOR HEART SURGERY
Thomas J. E. O'Neill, M. D., Assistant Clinical Professor of Surgery, Women's Medical College of Pennsylvania, and Associate Professor of Thoracic Surgery, Hahnemann Medical College, Philadelphia

# Wednesday Oct. 6

■ HENRY DOUBILET, M. D.
New York

## Surgery

SOUTH KILBOURN HALL
MILWAUKEE AUDITORIUM

Moderator: P. A. Midelfart, M. D., Eau Claire

■ WILLIAM J. GROVE, M. D.
Chicago

10:00 a. m.: DIAGNOSIS AND TREATMENT OF RECURRENT PANCREATITIS
Henry Doubilet, M. D., Associate Professor of Surgery, College of Medicine, New York University, New York City

10:45 a. m.: THE USE OF ACTH AND CORTISONE IN SURGICAL PATIENTS
William J. Grove, M. D., Associate Professor of Surgery, University of Illinois College of Medicine, Chicago

■ GEORGE S. BAKER, M. D.
Rochester, Minnesota

## Ophthalmology and Otolaryngology

EAST ROOM
HOTEL SCHROEDER

Moderator: John W. Doolittle, M. D., Madison

■ JUSTIN M. DONEGAN, M. D.
Chicago

1:00 p. m.: Business meeting (following luncheon at 12:15 p. m.)

1:30 p. m.: RETROLENTAL FIBROPLASIA
Justin M. Donegan, M. D., Rush Associate Professor of Ophthalmology, University of Illinois College of Medicine, Chicago

2:10 p. m.: THE EVALUATION OF HEARING DISABILITY IN MEDICAL AND LEGAL CASES
Meyer S. Fox, M. D., Milwaukee

2:30 p. m.: RECENT ADVANCES IN THE TREATMENT OF RETINAL DETACHMENT
John B. Hitz, M. D., Milwaukee

3:00 p. m.: TREATMENT OF PAINFUL NEURALGIAS OF THE HEAD
George S. Baker, M. D., Assistant Professor of Neurosurgery, Mayo Foundation Graduate School, University of Minnesota Medical School, Rochester, Minnesota

# ROUND TABLE LUNCHEONS

## *Wednesday, October 6*

*Note:* **All luncheons listed will be held at the Hotel Schroeder from 12:15 until 2:00 p. m. Attendance is limited, so if you have not made your reservations, do so immediately. List three choices in order of preference. Cost: $2.50 per luncheon. Make your check payable to the State Medical Society of Wisconsin.**
**If any reservations remain, tickets can be secured in the fifth floor foyer of the Hotel Schroeder at 12:00 noon on the day of the luncheon.**

1. JOHN I. BREWER, M. D., Chicago: **"Abnormalities of Menstruation"**
   Chairman: F. W. Hofmeister, M. D., Milwaukee
2. HENRY DOUBILET, M. D., New York: **"Status of Emergency Operation on the Acute Abdomen"**
   Chairman: Kenneth E. Lemmer, M. D., Madison
3. CHARLES S. CAMERON, M. D., New York: **"To Tell or Not to Tell" (The Cancer Patient)**
   Chairman: James E. Conley, M. D., Milwaukee
4. WILLIAM J. GROVE, M. D., Chicago: **"The Direct Surgery of Arteriosclerosis with Particular Reference to Abdominal Aortic Aneurysms"**
   Chairman: A. R. Curreri, M. D., Madison
5. OVID O. MEYER, M. D., Madison: **"Newer Drugs and Their Uses"**
6. FRANCIS D. MURPHY, M. D., Milwaukee: **"Cardiac Emergencies"**
7. HOWARD J. TATUM, M. D., New Orleans: **"Pregnancy Complicated by Heart Disease"**
   Chairman: W. V. Luetke, M. D., Madison
8. DONALD M. WILLSON, M. D., Milwaukee: **"Benefits and Hazards from the Administration of Potassium Salts"**

### *Special Luncheons*

9. Public Health: **"Viral Hepatitis"** with NED G. MAXWELL, M. D., Milwaukee, as discussion leader
10. Pathologists: GEORGE M. HASS, M. D., Chicago: **"Present Status of Human and Experimental Studies on the Pathogenesis of Arteriosclerosis"** (Followed by meeting of Wisconsin Society of Pathologists)
11. Section on **Ophthalmology and Otolaryngology:** Luncheon, followed by scientific program in same room. Speakers: JUSTIN DONEGAN, M. D., Chicago; GEORGE BAKER, M. D., Rochester, Minnesota; and DRS. MEYER FOX and JOHN HITZ, Milwaukee

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# CLOSING SCIENTIFIC ASSEMBLY

**JUNEAU HALL** **MILWAUKEE AUDITORIUM**

Moderator: M. G. Rice, M. D., Stevens Point

**2:30 p. m.: EVALUATION OF SURGICAL PROCEDURES IN UTERINE AND PERINEAL RELAXATION**
John I. Brewer, M. D., Chicago

**3:00 p. m.: CANCER: RESEARCH PROGRESS**
Charles S. Cameron, M. D., New York City

**3:30 p. m.: TEN-MINUTE RECESS**

**3:40 p. m.: THE PRESENT STATUS OF SURGICAL TREATMENT OF DUODENAL ULCER**
Henry Doubilet, M. D., New York City

**4:10 p. m.: THE SURGERY OF HEART DISEASE, EXCLUDING VALVULAR DEFECTS**
Thomas J. E. O'Neill, M. D., Philadelphia

# Annual Dinner

BALLROOM OF THE HOTEL SCHROEDER

## WEDNESDAY—OCTOBER 6

Presiding Officer: H. Kent Tenney, M. D., President of the State Medical Society of Wisconsin

**Presidential Address** (15 minutes): H. Kent Tenney, M. D., Madison

**Address of the Incoming President** (15 minutes): Arthur J. McCarey, M. D., Green Bay

**Presentation of Certificates to New Members of the "50 Year Club":**

Albert Butler, Ashland
Leslie E. Coffin, Tucson, Arizona
Edward P. Crosley, Stevens Point
Otis H. Epley, New Richmond
B. O. Fosse, Beloit
P. H. Fowler, Plain
Maynord H. Fuller, Green Bay
Charles W. Giesen, Superior
Alexander F. Harter, Rhinelander
Harry J. Heeb, Milwaukee
John G. Hoffmann, Hartford
Nicholas J. Knauf, Chilton
William T. Kradwell, Wauwatosa
L. M. Lundmark, Ladysmith
Alfred C. Radloff, Plymouth
Bertha Reynolds, Avoca
John E. Schein, Oshkosh
M. M. Spitz, Milwaukee
Frank B. Taylor, Madison
David J. Twohig, Fond du Lac
Robert G. Washburn, Milwaukee
May R. Wells, Belleville, Illinois
Stephen E. Williams, Chippewa Falls

**Entertainment:** Professional entertainment in the form of music and novelty acts will be featured for a full hour following the program listed above.

**Dance:** Following the professional entertainment and a short intermission period to clear the floor, dancing to the music of Steve Swedish and his orchestra will take place until midnight.

# SCIENTIFIC EXHIBITS

## *Reflect Varied and Significant Research of Wisconsin Physicians and Medical Groups*

The scientific exhibits listed below have been selected for the 1954 Annual Meeting by Dr. M. G. Rice, Stevens Point, a member of the Council on Scientific Work. The exhibits will be open in Bruce Hall of the Milwaukee Auditorium from 9:00 a.m. to 5:00 p.m. on Monday, October 4, from 8:00 a.m. to 5:00 p.m. on Tuesday, October 5, and on Wednesday, October 6, from 8:00 a.m. until 3:00 p.m.

Provision has been made on the time schedule so that these fine exhibits can be studied in the early morning hours before the formal scientific meetings and at the close of the morning sessions before lunch, as well as during a special recess period in the afternoon. The Council on Scientific Work appreciates the effort which went into the preparation of these exhibits and recommends that all physicians attending the Annual Meeting study their content and discuss the material with those in attendance.

### A. Fifth Street Foyer and Juneau Hall: Milwaukee Auditorium

**S-1, 2, 3 NEW SCIENTIFIC FILMS ON CANCER**

**American Cancer Society, Milwaukee and Wisconsin Divisions**

Special films of professional interest, prepared and available through the American Cancer Society, will be shown each day during the scientific programs and recess periods so those not interested in the specific papers presented can view these films. The "theatre" will be located in the foyer immediately adjacent to the main meeting hall.

As a corollary of the showing of cancer films, a special exhibit on lung cancer will be provided on the side of the "theatre" facing the foyer. The exhibit will show visually the four stages of carcinoma of the lung and the probable prognosis of each.

**S-4, 5 VASCULAR SURGERY AND THE ARTERY BANK**

**Department of Surgery, Marquette University School of Medicine, with the cooperation of Milwaukee County Hospital and Veterans Hospital, Wood, Wisconsin, E. A. Bachhuber, M.D., and James Sullivan, M.D., Milwaukee**

Indications for blood vessel grafting will be listed. Methods for collection and preservation of material for an artery bank and safeguards necessary will be described and illustrated where possible. Dog aortas with grafts of varying duration will be demonstrated. Actual case reports will be presented.

**S-6, 7 COLUMBIA HOSPITAL MEDICAL STAFF**

**Milwaukee, Wisconsin**

The exhibit is made up of graphic representations of work in subjects of special interest performed by various members of the hospital staff.

*Non-Tuberculous Acid-Fast Bacillus Infections of the Lung:* Dann B. Claudon, M. D.

*Plethysmography in Vascular Diseases:* James E. Conley, M. D.

*Cyclic Changes in Cervical Mucus:* Benjamin E. Urdan, M. D.; Alvin M. Kurzon, M. D.

*Anticoagulant Therapy:* John O. Chamberlain, M. D.; Fred W. Madison, M. D.

*Porphyrinuria in Lead Poisoning:* Elston L. Belknap, M. D.; Margaret C. Perry, M. A.

*Paper Electrophoresis:* Robert R. Koenig, M. D.; Benedict M. Polcyn, M. D.; Gorton Ritchie, M. D.

**S-8 THE HUMAN HEART**

**Wisconsin Heart Association**

The Wisconsin Heart Association display will feature a set of models of the healthy and diseased heart, which were prepared by medical sculptor, Abram Belskie. These lifesize hearts show the configuration and relative position of the heart as seen in a roentgenograph. Included in the set are models of an average normal heart, transverse heart, vertical heart, three models of hearts with mitral stenosis, aneurysm of the aorta, casts of the chambers and great vessels, hypertensive heart, cor pulmonale.

**S-9 EPILEPSY AS TREATED AT MILWAUKEE CHILDREN'S HOSPITAL**

**F. J. Millen, M.D., Milwaukee Children's Hospital and Marquette University**

The exhibit will contain placards indicating statistical and general facts, as well as some specific data, concerning epilepsy in children. Electroencephalograms, x-rays, pneumoencephalograms, and arteriograms are shown as part of the work-up of the case of an epileptic child. Differential diagnosis and clinical work-up, as well as the

mechanisms of an epileptic clinic in handling a child, are described. Modern drug therapy and its indications are included.

**S-10 A COMMON CAUSE OF PAINFUL SHOULDER: SUPRASPINATUS TENDINITIS**

**Mark W. Garry, M. D., and Mark J. Cicantelli, M. D., VA Center, Wood, Wisconsin, and Marquette University School of Medicine**

A frequently overlooked cause of painful shoulder is supraspinatus tendinitis. This rather common affection can be treated simply and effectively if recognized early; failure to identify it results in stubborn disabilities. Charts, line drawings, and photographs will be used to present clearly the diagnostic highlights and therapeutic regimen for this disorder.

**S-11 NEW NEUROSURGICAL PROCEDURE FOR RELIEF OF PAIN**

**David Cleveland, M. D., VA Center, Wood, Wisconsin, and Marquette University School of Medicine**

Stereoscopic slides and drawings to demonstrate modern and newer neurosurgical operations.

**S-12 BLOOD VESSEL BANK**

**James M. Sullivan, M. D., and Edward Bachhuber, M. D., VA Center, Wood, Wisconsin, Marquette University School of Medicine, and Milwaukee County Hospital**

**S-13, 14 MINIFILMS MAY SUGGEST PULMONARY DISEASE**

**Wisconsin Anti-Tuberculosis Association, Deaconess Hospital, and Westinghouse Corporation**

Patients entering general hospitals for diagnosis and therapy should receive at least a miniature chest x-ray film. Frequently, cardiac abnormalities, carcinoma, tuberculosis, or other pulmonary pathology are suggested. 14 x 17 inch films and a brief history will help demonstrate the value of this procedure for routine hospital admissions.

**S-15 GRANULOMATOUS TUMORS AND SIMILAR PULMONARY LESIONS**

**VA Center, Wood, Wisconsin, and Marquette University School of Medicine, T. J. Pfeffer, M. D.**

Reproductions of chest films showing various pulmonary lesions which may be classified by the pathologist as granulomatous processes. One or more examples of pulmonary lesions simulating granulomas will also be shown.

**S-16 VIRUS AND RICKETTSIAL DISEASES**

**State Laboratory of Hygiene, University of Wisconsin, and State Board of Health, Madison**

There will be a presentation by chart of some of the common virus and rickettsial diseases which occur in this country, some of them in Wisconsin. The presentation will give a short description of the disease, the laboratory methods that are used for its recognition, the kind of specimens that are required to make the determinations, and how they should be collected and sent to the State Laboratory of Hygiene. The presentation will cover virus diseases of the respiratory tract and central nervous system, rickettsial diseases, and others. The charts will be concise, in small groups, and easily read; and at the booth there will be mimeographed sheets of the presentation that will be distributed. In addition, there will be a continuous slide presentation of two representative diseases—respiratory and central nervous system disease.

**S-17, 18 PULMONARY FUNCTION AND ANESTHESIA IN THORACIC SURGERY**

**VA Hospital, Madison**

The exhibit consists of three sections: Pulmonary Function, Anesthesiology, and Surgery.

Section One demonstrates the normal and abnormal spirograms of vital capacity, maximum breathing capacity, and the nitrogen meter tracings of the single breath $O_2$ test and the residual air studies.

Section Two demonstrates problems in anesthesia. Methods are shown for controlling oxygenation, elimination of carbon dioxide, and maintenance of circulation. The use of the Carlen intratracheal tube and the control of respiration to aid the thoracic surgeon are shown.

Section Three consists of several case reports illustrating the function studies, the x-rays, and the pathology of the resected lesions.

**S-19 PATHOLOGY OF BRONCHIAL ASTHMA**

**S. B. Crepea, M. D., University of Wisconsin Medical School**

Color slides illustrating the changes in seriously ill asthma patients will be shown. Correlation between the pathological changes and the necessary symptomatic therapy will be made.

**S-20, 21 HYDROCEPHALUS**

**Henry M. Suckle, M. D., Madison**

The newer diagnostic methods to determine the type of hydrocephalus and also the treatment are presented. The basic types of hydrocephalus will be demonstrated, and the available methods of treatment will be illustrated.

**S-22 DIAGNOSTIC AIDS IN CONGENITAL AND ACQUIRED HEART DISEASE**

**Departments of Medicine, Radiology, and Surgery, University of Wisconsin Medical School**

Angiocardiograms and cardiac catheterization results, including pressure changes before and after surgery, will be presented. The value of these tests in quantitating the degree of cardiovascular abnormalities, as well as in establishing the specific diagnosis, will be graphically presented. Their value as an aid toward disposition of the cardiac patient will also be evaluated.

## B. Bruce Hall (Exhibit Hall): Milwaukee Auditorium

**S-26, 27 PRACTICAL BALLISTOCARDIOGRAPHY**

**R. Rice, M. D., T. Calvy, M. D., I. Waldman, M. D., Regional Office, Veterans Administration, Milwaukee**

A report on a two-year experience with the Dock, Arbeit, and Glennite ballistocardiographs will be presented. Attempts at recording displacement, velocity, and acceleration ballistocardiographic tracings will be

detailed; and the practical difficulties encountered due to instrumentation will be noted.

Errors in identifying individual components of ballistocardiographic curves with integrated, superimposed electrocardiograms will be demonstrated.

**S-30, 31 RESPIRATORY ALLERGIES IN THE FARM POPULATION**

**Leon Unger, M. D., Albert H. Unger, M. D., Tybee Sue Meyers, M. T.**

In a series of 86 patients coming from farm areas, it was found that a large percentage gave positive tests for allergens which are primarily from farm products. In addition, a great number were found allergic to ragweed and other allergens. Very satisfactory results have been obtained by the specific measures of avoidance and hyposensitization. Photographs and charts illustrate the main findings.

**S-32 A POSITIVE PROGRAM FOR THE MANAGEMENT OF THE MULTIPLE SCLEROTIC**

**Edward P. Roemer, M. D., Madison**

The exhibit portrays steps suggested in the management of a case of multiple sclerosis, a program based on empirical methods. The program includes recognition, diagnosis, classification, medical regime, physical medicine program, psychotherapy, vocational counseling, vocational training, and job placement.

**S-37, 38 AUDIO-DIGEST FOUNDATION**

A professionally sponsored service offering tape recorded medical literature by subscription. Profits are contributed to the nation's medical schools through the American Medical Education Foundation.

**S-39-42 TESTING THE DRINKING DRIVER**

**American Medical Association**

Three-dimensional figures portray (1) progressive degrees of intoxication, (2) amount of alcohol required to produce different stages of drunkenness, and (3) the corresponding anatomical portions of the brain that are anesthetized by the ingestion of alcohol. Lifelike, actual size reproductions of the brain are colored to show those portions which are affected in different stages of intoxication. The percentage of blood alcohol for each of the stages of intoxication is also shown.

**PHYSICIAN RESPONSIBILITIES IN HIGHWAY ACCIDENTS**

**American Medical Association**

The exhibit emphasizes the responsibility of the physician in advising his patient about driving a motor car. This will include advice about physical and mental conditions that preclude all driving, as well as about instances following the administration of certain anesthetics and drugs when the patient should refrain from driving for a certain number of hours.

**S-43 ETIOLOGY OF MALPRACTICE**

**American Medical Association**

This is an exhibit fom the Bureau of Legal Medicine and Legislation, Committee on Medicolegal Problems. The exhibit portrays situations which might give rise to suits for malpractice against a physician. Warning admonitions are included.

The exhibit consists of two transparency cases, each containing eleven transparencies. One set of illuminated transparencies is entitled, "Asking for Suit"; the other set is devoted to the subject of "Consent for Operation." The center portion of the exhibit is devoted to the subject of "General Plan." Thirteen questions are found on the face of the panel; and by lifting small panels, the answer to each question is found beneath.

**S-44, 45 THE TEARING EYE—ITS TREATMENT WITH POLYETHYLENE TUBING**

**A. L. Rhoades, M. D., Jackson Clinic, Madison**

The exhibit is designed to show a simplified and highly gratifying method of treating a most aggravating ophthalmologic problem—the constantly wet, tearing eye—by means of a small polyethylene tube. The entire procedure is reduced to that of an office procedure.

The steps employed in placing the polyethylene tubes into the lacrimal drainage system are portrayed. The type of tube and the exhibitor's own innovation in the shape of the tubes is shown. Finally, photographs to show the tubes in position in the living patient are displayed.

**S-46, 47, 48 SECTION ON RADIOLOGY**

Section on radiology will consist of demonstration exhibits prepared by various practicing radiologists throughout the state of Wisconsin for purposes of demonstrating some newer radiological technics used in diagnosis and to describe radiological technics in diagnosis of various diseases, with the x-ray findings pertinent to these diseases. The purpose of this demonstration is to present to the medical profession the interesting radiological facts not on the radiological level entirely, but for the general medical profession at large.

**S-49, 50 MECHANICAL QUACKERY**

**American Medical Association**

This is an exposé of mechanical quackery from the Bureau of Investigation of the American Medical Association. Everything from a "magic horse collar," claimed to magnetize the iron in the blood, to a radioactive "rejuvenator" is presented by display of the actual quack device. Many other weird and humorous fake gadgets are shown. An extensive information file is incorporated as a part of the exhibit and contains descriptions and information concerning many more mechanical gadgets.

**S-51, 52 PREPARATION AND USE OF PLACENTAL SERUM**

**C. F. McDonald, M. D., and L. J. Van Hecke, M. D., for the Wisconsin Academy of General Practice**

Human placental serum can be easily collected and prepared for therapeutic use in the obstetrical division of any hospital. Originally the physicians exhibiting conjectured that the cells of the placenta should have teleological objectives of striving toward normality in the creation of a new being, sometimes within the structure of a very abnormal mother. If this were true, these cells should be expected to be a source of great creative, protective, and corrective potential. The serum's therapeutic use has shown effectiveness in certain disorders of hypersensitivity and poor response.

# TEACHING DEMONSTRATIONS

## *Special Daily Programs Offered for Direct Teaching to Small Groups*

Each day during the 1954 Annual Meeting there will be a series of teaching programs offered at the times indicated below. These programs are designed to present special problems in various fields which will be of special concern to the general practitioner. The Council on Scientific Work has had the special assistance of L. G. Kindschi, M. D., Monroe, in the development of these programs, with the cooperation of the special medical groups or departments conducting the teaching demonstrations.

This is an important part of the scientific program, and your active participation in the lectures and discussions is requested. All programs will be held in the main exhibit hall at the hours indicated.

### Demonstration Schedule

**Monday, October 4: 10:00–11:00 a.m. and 3:00–3:45 p.m.**
**Tuesday, October 5: 9:00–10:00 a.m. and 3:00–3:45 p.m.**
**Wednesday, October 6: 9:00–10:00 a.m.**

**S–57, 58, 59 MEETING THE NEEDS OF THE AMPUTEE**

**Ray Piaskoski, M. D., and Associates, VA Hospital, Wood**

This will be a demonstration of the modern teamwork concept of rehabilitation designed to meet the needs of the amputee. Rehabilitation of a severely disabled patient requires the coordinated effort of many individuals, including doctors, nurses, rehabilitation therapists and technicians, vocational counselors, social workers, the patient, his family, and friends. This demonstration emphasizes particularly the role of the physician, the physical therapist, the limb maker, and the vocational counselor. Patients will be used for demonstration purposes.

**S–55, 56 OB MANIKIN DEMONSTRATIONS ON SPECIAL PROBLEMS OF DELIVERY**

**Members of the Wisconsin Society of Obstetrics and Gynecology**

Each day teaching demonstrations on the subjects listed will be held, with the use of a manikin. Full opportunities for discussion and questions will be provided:

**Monday, October 4:**

**10:00–11:00 a.m.: Version Extraction and External Version:** L. T. Servis, M. D., Milwaukee

**3:00– 3:45 p.m.: Management of Transverse Presentation and Breech Presentation:** Elizabeth A. Steffen, M. D., Racine

**Tuesday, October 5:**

**9:00–10:00 a.m.: Version Extraction and External Version:** David J. Werner, M. D., Milwaukee

**3:00– 3:45 p.m.: Management of Transverse Presentation and Breech Presentation:** S. D. Austin, M. D., Green Bay

**Wednesday, October 6:**

**9:00–10:00 a.m.: Manual and Forceps Rotation of the Occiput Transverse and Occiput Posterior Presentations and Positions:** Russell Lewis, M. D., Marshfield

**S–53, 54 THE CRANIAL CAVITY**

**Frederick D. Geist, M. D., and Paul H. Settlage, M. D., Department of Anatomy, University of Wisconsin Medical School**

The daily demonstrations will be on certain aspects of the cranial cavity which are of special interest and concern to the general practitioner, not only as anatomical demonstrations, but as demonstrations directly related to clinical problems that are a consequence of disease or of injury. In one specimen the cranial meninges, cerebral veins, fluid spaces, meningeal vessels, and dural sinuses will be featured. The second specimen will present the dorsal view of the brain stem, and a complete laminectomy will show the roots of the cranial nerves and their relationships to other structures, the spinal nerve roots, and cauda equina.

**S–35, 36 THE POSTANESTHESIA RECOVERY ROOM**

**Wisconsin Society of Anesthesiologists**

This demonstration will be an exhibit of the equipment used in a postanesthesia recovery room and a demonstration and discussion of such equipment. Pictures of recovery rooms in various hospitals will be shown. The demonstrations will be under the general direction of J. W. Bookhamer, M. D., Milwaukee, and other members of the Wisconsin Society of Anesthesiologists.

**S–33, 34 ORTHOPEDIC DEMONSTRATIONS**

**Wisconsin Orthopedic Society**

A variety of demonstrations of special orthopedic problems of interest to the general practitioner will be presented. Included will be the treatment of fractures of the shaft of the humerus by hanging cast method, fractures of the ankle, and intramedullary nailing of the femur. The demonstrations are under the general direction of Joseph R. Stone, M. D., Milwaukee; and medical students will be used for demonstration purposes.

**S–28, 29 GROSS TISSUE DEMONSTRATIONS**

**Wisconsin Society of Pathologists**

The demonstration consists of currently available gross specimens, fixed and fresh, of special or general interest. They are drawn from surgical and autopsy cases. Wisconsin pathologists will discuss the material presented. The demonstrations are under the general direction of Gorton Ritchie, M. D., Milwaukee.

# . . . . THE PRESIDENT'S PAGE . . . .

IT WOULD really be impossible for a project the size of Wisconsin Physicians Service to exist very long without encountering some dissatisfactions and disagreements among the thousands of people involved in its thousands of transactions. But when we begin to find in these dissatisfactions a certain similarity and a certain familiarity by reason of repetition, and particularly when we find a certain resemblance between the etiology of these dissatisfactions and some more serious ones that find their way into deliberations of grievance committees, then it is time that we again call attention to certain important considerations in patient-physician relationships.

Perhaps this recent episode will serve to illustrate a situation which our insurance staff says is becoming all too common. About two months ago, a woman called and said that years ago I took care of her child; the child now needed a special type of surgery, and the mother asked if Doctor X was a good surgeon to do that kind of a job. I told her that Doctor X was an excellent surgeon in that field and I was sure he would take good care of her daughter. This, of course, was as physician to patient and not as an officer of the State Medical Society to the public.

But a few days ago I answered the telephone during office hours, and the instrument practically pulled my left eardrum out by the roots. It was this same mother wondering if I remembered saying that Doctor X would take good care of her child. Yes, I remembered it; was I wrong about Doctor X? No, Dr. X had been wonderful to her child, and she had no complaint whatever about him. "But you doctors!" the woman said; "you're just running a great big racket! Now I believe all the mean things I read about you in the papers and magazines! I am sorry I voted for President Eisenhower. He says he is against socialized medicine, and we'll have to have socialized medicine to protect poor folks from you doctors," etc., etc., ad myringotomy.

Well, I finally learned that her explosion was due to just having received a bill for $37.50 from an anesthesiologist, Doctor Y, of whom she had never heard. True, she admitted, her daughter reported that a nice man came to see her the night before her operation and said he would see her the next morning and that he would put a needle in her arm. That was all any of them knew about Doctor Y. She had already paid her hospital bill, on which there was an item of $25 for "operating room." That certainly should have covered everything that went on in the operating room. The woman wanted to know who the doctors thought they were, anyhow, to charge such prices for an anesthetic; and she was off on another tirade.

What is the moral of this story? To my mind, it brings up these points:

1. Most people are not aware of the increasing use of the specialized services of an anesthesiologist in general surgery. Therefore, even though the surgeon says he would like to have Doctor Y give the anesthetic for tomorrow's operation, the patient may completely miss the implication that Doctor Y will submit a separate bill for his services. To the patient, surgery, operating room, and anesthesia are all part of one large and somewhat unpleasant package; and he is correspondingly appalled at receiving a separate bill for each component. So, please, Mr. Surgeon, don't curtail the services of the anesthesiologist; but please, for goodness sake, do make sure that the patient knows what you are talking about.

2. The reluctance of many physicians to enter into financial discussions with their patients before operation is the perfectly natural consequence of our agelong tradition of having the welfare of the patient as our primary interest, with the financial return as a secondary consideration. Now this interest in the patient's welfare has not decreased one bit, but the patient's interest in the financial side has increased; and even though it is a bit against our inclination, it is essential that the discussion be held.

3. Patients seldom understand the provisions of their insurance policies. It has been said that this is due to overzealous salesmanship which makes them believe that they are "covered" for anything that happens. I don't believe that the salesman is always to blame,

by any means. I think many people just naturally forget a lot of those things. For example, do you know all the provisions of your automobile insurance policy? What about the fire insurance on your office equipment? In other words, if you are going to help the patient by utilizing his insurance, then help him to understand what he is getting.

4. The discrepancy in people's thinking that "my doctor is wonderful, but you 'doctors' are lousy" has much of its origin in simple little incidents like the one recounted. Yet, it is an important factor to deal with in maintaining our public relations because, after all, "public relations" is nothing in the world but a multitude of individual relations. If our individual relations are constantly strengthened, our public relations will also be correspondingly strengthened.

H Kent Tenney M.D.

## BUREAU FOR HANDICAPPED CHILDREN SCHEDULES ORTHOPEDIC FIELD CLINICS

Orthopedic field clinics for the last half of 1954 have been scheduled by the Bureau for Handicapped Children, State Department of Public Instruction. The clinics are conducted for persons under 21 years of age who come within the state's definition of a crippled child. It is preferred that referral be made by the family physician; but when this is not feasible, arrangements may be made by writing to the Bureau. Forms for the purpose of referral may be obtained from the Bureau of Handicapped Children and should be requested in advance of the clinic date. It is important that the Bureau know well in advance the number of persons desiring clinic services. Medical referral forms are made up for the individual clinics, so requests should specify for which clinic forms are wanted.

Families who return the signed referral form will be notified of the hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child; and if the public health nurse believes that the child referred to the clinic for orthopedic reasons is also in need of other services, the Bureau asks that it be notified of the fact.

| | |
|---|---|
| Manitowoc | September 1, 2 |
| Marinette | September 8 |
| Kenosha | September 15, 16 |
| Green Bay | September 23, 24 |
| Superior | September 29, 30 |
| La Crosse | October 12, 13, 14, 15 |
| Racine | October 20, 21 |
| Sheboygan | October 28, 29 |
| Rhinelander | November 3, 4 |
| Eau Claire | November 11, 12 |
| Appleton | November 18, 19 |
| Fond du Lac | December 1, 2 |
| Chippewa Falls | December 9, 10 |

Inquiries concerning these clinics may be addressed to The Bureau for Handicapped Children, 146 North, State Capitol, Madison 2, Wisconsin.

# Society Proceedings

## Green Lake–Waushara

Eight members of the Green Lake–Waushara County Medical Society met at the Hotel Whiting and Berlin Memorial Hospital, Berlin, on June 16.

*Dr. P. S. Pierson*, Veterans Administration Hospital, Wood, spoke on "The Diagnosis of Rheumatic Fever," and *Dr. M. J. Lustock*, Milwaukee, addressed the group on "Newer Drugs in the Treatment of Coronary Heart Disease."

A Rheumatic Fever Clinic was held at the Berlin Memorial Hospital in the morning. At the clinic, 16 young heart patients were examined by the speakers.

## Polk

A dinner meeting of the Polk County Medical Society was held on June 17 at the Paradise Lodge, Balsam Lake. Eighteen members were present as guests of *Dr. F. L. Whitlark* of Amery.

Mr. Paul Doege, sales coordinator of the Blue Shield plan, Madison, discussed progress in the Blue Shield plan for rural areas. He was accompanied by Mr. Ray Koenig of the Blue Shield office.

The county society went on record as favoring the immediate procurement of a full-time county health nurse.

## Richland

On June 4 a meeting of the Richland County Medical Society was held at the Park Hotel, Richland Center. *Dr. J. M. Wilkie*, Madison, spoke to the 12 members present on "Chest Diseases for the General Practitioner."

## Trempealeau–Jackson–Buffalo

Members of the Trempealeau–Jackson–Buffalo County Medical Society met at the Club Midway, Independence, on June 22. Rheumatic fever problems were discussed.

Wives of the physicians were invited to attend.

## Fifth Councilor District

The annual meeting of the Fifth Councilor District was held at Elkhart Lake on June 17. *Dr. R. G. Yost* of Manitowoc was elected president and *Dr. Wallace Marshall* of Two Rivers, secretary–treasurer.

## Sixth Councilor District

Members of the Sixth Councilor District engaged in a golf game at the South Hills Country Club, Fond du Lac, followed by dinner and a scientific session on June 15.

The scientific program was held at the auditorium of St. Agnes Hospital, School of Nursing, Fond du Lac, starting at 4:00 p.m. *Dr. W. S. Middleton*, Madison, spoke on "Current Medical Aspects of Jaundice," and Dr. Charles Puestow of Chicago spoke on "Current Surgical Aspects of Jaundice."

Following dinner, Mr. C. H. Crownhart, secretary of the State Medical Society, presented a talk on "Health Insurance Makes News."

J. B. Roerig & Company furnished refreshments before the dinner.

## Wisconsin Radiological Society

The annual meeting of the Wisconsin Radiological Society was held on June 5 at Leathem Smith Lodge, Sturgeon Bay, under the direction of *Dr. Ralph Troup* of Green Bay.

Dr. Paul C. Hodges of the University of Chicago presented the principal paper on "Fibrous Dysplasia of Bone." In addition, papers were presented by *Drs. Irving Cowan*, Milwaukee; *Eugene Pitts*, Racine; *C. F. Sherman*, Madison; *Abraham Marck*, Milwaukee; *Donald Babbitt*, Milwaukee; and *Ralph Frank*, Eau Claire.

The following were elected officers for the coming year: Dr. Irving Cowan, president; Dr. Ralph Frank, president-elect; and *Dr. William Moir*, Sheboygan, secretary-treasurer.

The Wisconsin Radiological Society is open to all specialists in radiology who are Diplomates of the American Board of Radiology. Anyone not already a member who wishes information or wishes to join the society should communicate with Dr. William Moir, Memorial Hospital, Sheboygan.

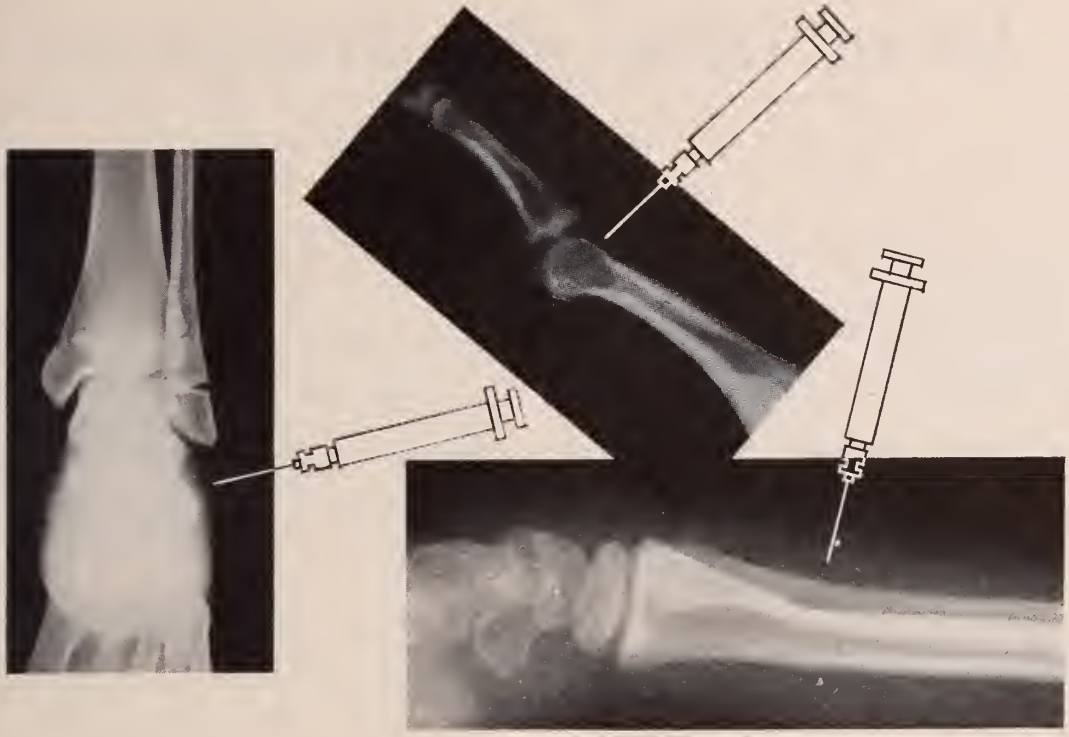
## Wisconsin State Department of Public Welfare

The Division of Mental Hygiene of the Wisconsin State Department of Public Welfare and the Wisconsin Psychiatric Institute presented a symposium on "Recent Developments in Brain Function and Intelligence" in the auditorium of the University of Wisconsin Medical School on June 28.

The program was supported in part with funds available under the National Mental Health Act.

## Wisconsin Heart Association

*Dr. H. L. Correll* was installed as president of the Wisconsin Heart Association for the year beginning June 1954 when the association met at Madison on June 5. Doctor Correll is from Milwaukee.



# Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

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1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, J. Bone & Joint Surg. *35-A*:604 (July) 1953.
2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, Am. J. Surg. *87*:384 (March) 1954.

# News Items and Personals

## State Board of Health Re-Elects Officers

*Dr. S. E. Gavin*, Fond du Lac, and *Dr. Samuel Henke*, Eau Claire, were re-elected as president and vice-president respectively of the State Board of Health on July 7.

Doctor Gavin has been a member of the Board since 1943 and has served as its president since 1948. Doctor Henke was first appointed to the Board in 1947 and has been its vice-president since 1949.

## Dr. F. H. Kelley Honored

*Dr. F. H. Kelley*, who has practiced at Merrill for 49 years, was honored at a testimonial banquet on May 24 at the Badger Hotel, Merrill. One hundred and fifty citizens, including Doctor Kelley's son, James, executive secretary of the Medical Society of Milwaukee County, attended the occasion.

Doctor Kelley was born in November 1878 in Mauston. He graduated from the Milwaukee Medical College in 1905 and established his practice at Merrill the same year.

## Doctor Hildebrand Addresses Canadian GP's

*Dr. William B. Hildebrand*, Menasha, addressed the yearly convention of the College of General Practice of the Canadian Medical Association held in Vancouver, British Columbia, in June.

Doctor Hildebrand is president of the American Academy of General Practice.

## Doctor Ferguson Moves to Juneau

*Dr. Edward C. Ferguson*, formerly of Waupun, has moved to Juneau, where he has formed a partnership with Dr. Norman Erickson. Doctor Ferguson will continue as a staff member of the Waupun Memorial Hospital and has become a member of the staffs of the hospitals at Beaver Dam as well.

## Doctors Semmens and Sinnett Have Moved

*Dr. J. P. Semmens* and *Dr. J. M. Sinnett*, formerly of Waupun, have left the community. Doctor Semmens is now a lieutenant commander in the Navy and has been assigned to the Naval Hospital, Portsmouth, Virginia, where he will be a resident physician in obstetrics and gynecology.

Doctor Sinnett expects to be released from the Naval Reserve in October and is planning to establish a private practice in Jacksonville, Florida.

## Hortonville Honors Doctor Towne

In recognition of 47 years of medical practice, 25 of them in Hortonville, that village paid tribute on June 20 to *Dr. William H. Towne*.

Doctor Towne was born in Waupun in 1881. He was graduated from the Wisconsin College of Physicians and Surgeons, Milwaukee, in 1907 and served a year at the Veterans Hospital, Waupaca, before setting up his practice at Shiocton. Twenty-one years later he moved to Hortonville.

## Doctor Pfefferkorn Attends Meetings

*Dr. E. B. Pfefferkorn*, Oshkosh, attended the annual meeting of the American College of Chest Physicians in San Francisco in June. He is a past president of the state chapter.

Doctor Pfefferkorn also attended the meeting of the American Medical Association which was held at San Francisco in June.

## Dr. Dean Willson Is Board Diplomate

*Dr. Dean D. Willson*, Fond du Lac physician, has been certified by the American Board of Obstetrics and Gynecology. He received his medical degree from the University of Michigan in 1945, interned at Harper Hospital, Detroit, and located at Fond du Lac in 1951 following a period of military service.

## 50 Years of Practice at Chilton Observed

The fiftieth anniversary of *Dr. N. J. Knauf* in the practice of medicine in Chilton was celebrated on June 20 by friends of Doctor Knauf. A six o'clock dinner was served at the Joseph Schweitzer Cottage on Lake Winnebago.

## Burlington Hospital Names Officers

At a staff meeting held on June 23, officers of the Burlington Memorial Hospital were elected. They include: *Dr. H. W. Granzeau*, chief of staff; *Dr. Lief Erickson*, vice-president; and *Dr. W. C. Sroka*, secretary–treasurer.

## Big Bend Physician Retires

*Dr. R. E. Boldt*, who practiced at Big Bend for the last 16 years, retired on July 1. Doctor and Mrs. Boldt will spend the summer at their cabin near Park Falls and will then visit their daughter and family in Michigan before traveling for about a year.

*Dr. J. L. Raschbacher*, formerly of Kewaskum, has taken over Doctor Boldt's practice.

## Dr. Frank Wright in New Office

*Dr. Frank Wright*, Appleton, has opened his own office in the Irving Zuelke Building. He was formerly associated with *Dr. E. N. Krueger*.

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## New Neillsville Hospital Officers Elected

Six doctors of Clark County are charter members of the staff of the new Neillsville Memorial Hospital. They are *Drs. A. P. Hable* of Loyal; *Kenneth Manz*, Neillsville; *W. A. Olson*, Greenwood; *M. V. Overman*, Neillsville; *Milton C. Rosekrans*, Neillsville; and *Sarah Rosekrans*, Neillsville.

At an organizational meeting on July 1, the following officers were elected: president and chief of staff, Dr. M. C. Rosekrans; vice-president, Dr. M. V. Overman; and secretary, Dr. Sarah Rosekrans.

## THIRD AND TWELFTH DISTRICTS NEWS

Several physicians from the Third and Twelfth Councilor Districts appeared on the program of the fifty-ninth annual meeting of the Upper Peninsula Medical Society on June 18 and 19. The program was held at the Riverside Country Club, Menominee, Michigan.

*Dr. John Schindler*, Monroe, spoke on "Group Psychotherapy," and *Dr. Joseph W. Gale*, Madison, spoke on "What Surgery Has to Offer in Pulmonary Disease." Other speakers were *Dr. James Conway*, Milwaukee, and *Dr. Harry Beckman*, Milwaukee.

## Doctor Peterman Attends Pediatric Congress

*Dr. M. G. Peterman*, Milwaukee, attended the Pan-American Congress of Pediatrics in South America in August. He was in Sao Paulo from August 1 to 8 and in Rio de Janeiro from August 8 to 12.

## Doctor Silbar Associates with Father

*Dr. John D. Silbar* has associated with his father, *Dr. Sidney J. Silbar*, in the practice of urology. Their office is located at 536 West Wisconsin Avenue, Milwaukee.

## Doctor Ellenz in Postgraduate Work

*Dr. George B. Ellenz* of Wisconsin Dells has left his practice there. He will study radiology for the next three years at Ancker Hospital, St. Paul.

## Madison General Hospital Physicians Meet

*Dr. H. Kent Tenney, Jr.*, Madison, president of the State Medical Society, was guest speaker at the Madison General Hospital graduation banquet for the house staff on July 1. Ninety-five staff interns and University of Wisconsin Medical School seniors attended the banquet.

*Dr. A. A. Quisling*, Madison, chairman of the Intern and Resident Committee, presided; and *Dr. C. O. Vingom*, Madison, chief of staff, congratulated the graduating interns and welcomed the new intern staff and guests.

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## Doctor Belknap to Head New Department

*Dr. E. L. Belknap*, Milwaukee, will head a new department of occupational and environmental medicine this fall at the Marquette University School of Medicine. He has been on the faculty of the medical school since 1928 and took over his new duties on July 1. During the summer he will attend several conferences and meetings on industrial medicine in Europe.

Doctor Belknap was graduated from Johns Hopkins Medical School in 1923.

## MARRIAGES

*Dr. Ann Bardeen*, Madison, to Dr. Ernst O. Henschel, Prince Albert, Saskatchewan, Canada, June 17.

*Dr. David A. Smith*, Eau Claire, to Alice Ann Hammer, Appleton, July 10.

## SOCIETY RECORDS

### New Members

Jack A. Peterson, 555 East Brown Street, Waupun.

G. B. Fauley, Baileys Harbor.

L. L. Keppler, Jr., Milwaukee Children's Hospital, Milwaukee.

S. C. Myers, Veterans Administration Hospital, Wood.

D. P. Epperson, 113 North Third Street, Watertown.

J. H. Lunseth, 8410 West Gridley Avenue, Wauwatosa.

R. M. Quetsch, 1567–G Pershing Drive, Presidio, San Francisco, California.

### Changes of Address

Robin Smith, Neenah, to 8540 Reseda Boulevard, Northridge, California.

J. S. Stehlin,* Milwaukee, to Base Hospital, Ellington Air Force Base, Houston, Texas.

J. A. Larkey, Philadelphia, Pennsylvania, to 3818 North Frederick, Milwaukee.

R. W. Schroeder, Fond du Lac, to 1013 North 33rd Street, Milwaukee.

J. D. Silbar, Madison, to 4540 North Wilson Drive, Milwaukee.

C. P. Giesen, Milwaukee, to Veterans Administration Hospital, Tomah.

L. M. Gorenstein, La Crosse, to 1053 North Holmes Street, Indianapolis, Indiana.

E. H. Johnson, Madison, to 862 South Rose Street, Turlock, California.

E. F. Brandt,* New York, to 2044 North 86th Street, Milwaukee.

R. P. Reik,* Milwaukee, to U.S.A.F. Dispensary, 7532nd M & S Squadron, A.P.O. 218, % Postmaster, New York, New York.

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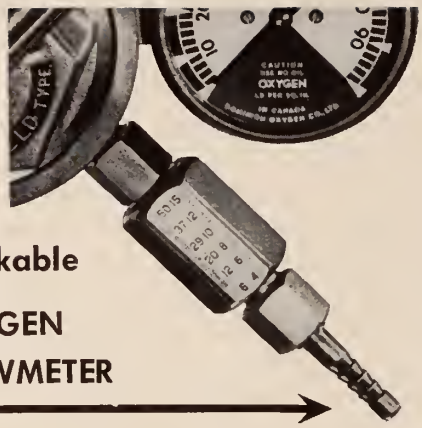


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G. A. Dedinsky, Milwaukee, to Box 73, Smock, Pennsylvania.

J. T. Hotter, Iowa City, Iowa, to 1563 South 72nd Street, West Allis.

E. R. Liebl, Madison, to 2200 West Kilbourn Avenue, Milwaukee.

E. J. Kiefer, Milwaukee, to 116 South Commercial, Neenah.

Eleanor V. Kuehn, Madison, to 3722 Branting Lane, Milwaukee.

K. J. Stollenwerk,* Fort Campbell, Kentucky, to 46th Armored Medical Battalion, 4th Armored Division, Fort Hood, Texas.

E. H. Schalmo, Aberdeen Proving Ground, Maryland, to 1729 South 11th Street, Milwaukee.

M. E. Foley, Beaver Dam, to St. Nazianz.

G. B. Ellenz, Wisconsin Dells, to Charles T. Miller Hospital, St. Paul, Minnesota.

John T. Skemp, La Crosse, to 5000 West Chambers Street, Milwaukee.

Woodruff Smith, Ladysmith, to Box 631, Aliquippa, Pennsylvania.

T. W. Dorman,* Janesville, to Wurtsmith Air Force Base, Oscoda, Michigan.

J. A. Palese, Rochester, New York, to 725 West Taylor Street, Chicago, Illinois.

*Military Service.

## DEATHS

Dr. Ralph M. Fellows, medical director of the Milwaukee County Asylum for the Chronic Insane, died on June 20 at the age of 59 years.

Born on August 28, 1894, in Salisbury, Missouri, he received his medical degree from Bellevue Medical College, New York, in 1922. He interned at Bellevue Hospital, New York, and at the U. S. Public Health Service Hospital at Ellis Island. For approximately nine years he was in the general practice of medicine at Salisbury, Missouri, and then took postgraduate work at Boston and Philadelphia.

For a year he was with the U. S. Public Health Service at Galveston, Texas, and for five years was a staff physician and later medical director of the Menninger Clinic and Sanitarium at Topeka, Kansas.

From 1936 to 1940 he was superintendent of Osawatomie State Hospital at Osawatomie, Kansas, and in June 1940 he became assistant medical director of the Milwaukee County Hospital for Mental Diseases. In January 1942 he was named chief senior

physician at the Milwaukee County Asylum for the Chronic Insane and was medical director of that institution from 1942 to the time of his death.

From August 1944 to January 1946 he served with the U. S. Navy as a lieutenant commander.

In May 1954 Doctor Fellows was honored for his work in mental health by being presented with the third annual award of the Milwaukee County Society for Mental Health.

Doctor Fellows was a member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association. He was also a member of the American Psychiatric Association and the Central Neuropsychiatric Association, a Fellow of the American College of Physicians, and a Diplomate of the American Board of Psychiatry and Neurology.

He is survived by his widow and two brothers, Dr. William W. Fellows, medical director of the Veterans Administration Hospital, Albany, New York, and Aubrey of Salisbury, Missouri.

**Dr. Arthur C. Niemann**, Milwaukee physician, died unexpectedly on June 21 while visiting his daughters in Malta, Montana.

Born on July 26, 1886, he was 67 years of age at the time of his death. He was graduated from the Marquette University School of Medicine in 1908 and interned at Milwaukee County Hospital for two years.

For more than 20 years Doctor Niemann specialized in eye, ear, nose, and throat. He was in semi-retirement for a number of years because of ill health.

Surviving him are his widow, Nancy, and two daughters, Mrs. Luise Hanson and Miss Nancy Niemann, both of Malta, Montana.

**Dr. Glenn F. Treadwell**, 76, Friendship physician for 42 years, died on June 20 at a Portage hospital.

He was born in Illinois on June 23, 1877, and was graduated from the Marquette University School of Medicine in 1910. He interned at Milwaukee County Hospital and moved to Friendship in February 1912.

In September 1952, Doctor Treadwell was honored by friends, neighbors, and patients for his 40 years of medical service to the community.

He was a member of the Columbia–Marquette–Adams County Medical Society, the State Medical Society, and the American Medical Association.

Surviving are his widow, Nell, and a daughter, Mrs. Jeanne Fish.

**Dr. Arthur F. Stueck**, 64, who practiced at Manitowoc for more than 35 years, died at a cottage on Eggers Point, Kangaroo Lake, Door County, on June 26.


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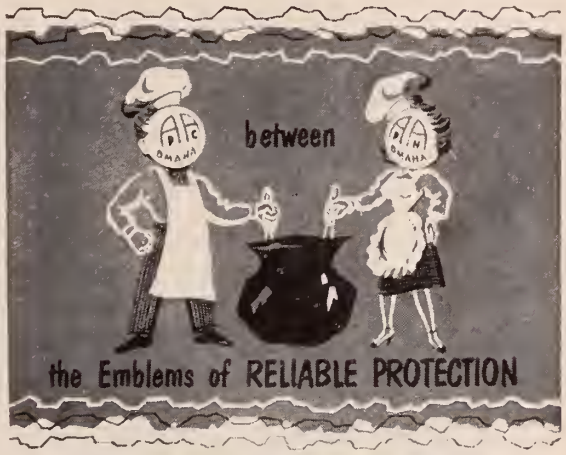


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Doctor Stueck was born October 26, 1889, in Mishicot and was graduated from Marquette University School of Medicine in 1914. He interned at Mt. Sinai Hospital, Milwaukee.

During World War I, he served with the U. S. Army as a captain. He engaged in the practice of medicine in Milwaukee before locating in Manitowoc.

He was a member of the Manitowoc County Medical Society, the State Medical Society, and the American Medical Association.

Surviving him are his widow, Helen; two daughters, Mrs. Jerome Levendusky of Milwaukee and Mrs. Beverly Hatch of Manitowoc; a son, Arthur, presently in the Air Force at Laredo, Texas; and a sister, Mrs. Joseph Mudroch of Columbus, Wisconsin.

**Dr. S. Wade Doolittle**, retired Lancaster physician, died at a Madison hospital on July 3 at the age of 83 years.

He was born in Evansville on September 1, 1870, and received his medical degree from the University of Louisville, Louisville, Kentucky. He practiced at Spencer, Wisconsin, for five years and in 1899 located at Lancaster. For some years he practiced with his younger brother, Dr. J. C. Doolittle, who preceded him in death.

Doctor Doolittle took postgraduate work at the University of Vienna, Austria, and in 1918 volunteered for service in World War I.

He was a former member of the Grant County Medical Society, the State Medical Society, and the American Medical Association and was a past president of the Grant County Medical Society.

Survivors include his widow, Alice; a grandson; two great grandchildren; and nieces and nephews.

**Dr. Wayne F. Cowan**, 75, Stevens Point, died at his home on July 3.

He was born on January 15, 1879, was graduated from the George Washington University School of Medicine, Washington, D. C., in 1905, and interned at Garfield Memorial Hospital in Washington. At the time of his death he was health officer of Stevens Point, and he had served as physician at the Portage County Infirmary since January 1953.

Doctor Cowan served with the Army from 1916 to 1919, being discharged with the rank of major.

He was a member of the Portage County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. In 1934 he was named a Fellow of the American College of Surgeons.

Surviving him are his widow, Cornelia, and one son, John, Chicago.

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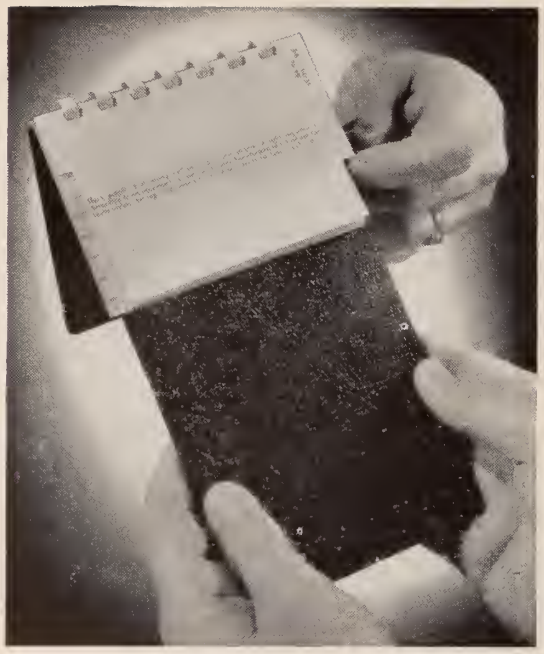

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# Facts about

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCO

# WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

## 100% or 80% Payments

One of the major problems with which the new Major Illness Expense Insurance plan is confronted arises out of the fact that benefits cannot be scheduled as is the case with the base program. That is, the claims arising out of major illness expenses will seldom involve appendectomies, tonsillectomies, or similar conditions, all of which can be "scheduled" for a particular benefit under the base program.

Therefore, the major illness program contains no scheduling of benefits and simply makes the provision that its benefits will be based upon the customary and reasonable charges encountered. Similar programs of other organizations, so far as the committee is aware, do not recognize such charges as entitling the policyholder to a 100 per cent reimbursement. A quite general figure is that the insuring organization will pay 80 per cent of such reasonable charges, thus placing the policyholder in a position of being partly responsible for his bills and being interested, financially, in the management of his costs.

Another factor enters the actuarial picture at this point. Blue Shield of Wisconsin, in providing benefits in its basic program, generally for acute conditions, is dealing for the most part with physicians in Wisconsin or in communities bordering upon this state. However, in providing benefits in the field of major illness expenses, it is recognized that many situations will arise in which benefits are being paid in other areas. The policyholder who suffers from a coronary may obtain medical care elsewhere as he decides to recuperate, for example, in the south during Wisconsin's winter months. His physician may recommend treatment elsewhere, or the patient himself may choose some other area for medical consultation.

This experience will have a direct bearing upon the rates which are charged for the Major Illness Expense Policy. Blue Shield of Wisconsin is but a state-wide organization. It cannot follow the pattern of some other organizations which specifically "rate" areas of the country based upon experience in each.

In developing the Major Illness Expense Policy, it was determined to provide reimbursement to the policyholder in the amount of 100 per cent of the charges of those physicians who participate in the basic program of Blue Shield. This is encouragement to the beneficiary to stay within the confines of his state, for it is the circumstances of Wisconsin upon which the entire program is based. If the patient seeks attention elsewhere, the plan will pay 80 per cent of reasonable and customary charges.

Question is raised concerning the nonparticipating physician in Wisconsin. It is said that the plan discriminates against him. It is a natural reaction for one in his position. But why is he not participating? It is because he does not now subscribe to the full payment provisions inherent to the ultimate success of Blue Shield. Thus, he may well make charges in excess of the basic program which will bring the professional services involved into the major illness expenses field, while the participating physician in the same situation would charge, and receive, the scheduled benefit.

Obviously, then, if the program fully recognized his charges, it would be discriminating in his favor and against the participating physician whose charges in many cases, because of the full payment provisions of the base program, would be within its total benefits even though the major illness program did not exist.

It must be recognized also that the participating physician does more than simply subscribe to the full payment concept of the basic Blue Shield program. He commits himself to that principle on a continuing basis. He can withdraw but annually. He guarantees the plan's benefit, thus eliminating the necessity of providing for losses through expenditure of capital obtained from outside sources. It is the participating physician who provides the "service concept" of Blue Shield.

In time, and with experience, it is hoped that the purchaser of the major illness expense program may have the option of buying, at additional cost to himself, 100 per cent protection in the event he seeks services from a nonparticipating physician, whether that physician is or is not a resident of Wisconsin. At this stage of development, however, that cannot be done.

(Excerpt from records of the Executive Committee of the Commission on Prepaid Plans, June 1954.)

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# CORRESPONDENCE

EDWARD D. SCHWADE, M.D.
324 East Wisconsin Avenue
Milwaukee, Wisconsin

Dr. R. S. Baldwin
Marshfield
Wisconsin

Dear Dr. Baldwin

After reading the article on the "Inheritance of Epilepsy" by Doctor O. P. Kimball in the May issue of the Wisconsin Medical Journal, I felt that it would be of some value to you to know that the opinions in this article are not generally accepted by the Physicians League on Epilepsy. While my own experiences do not bear out the findings of Doctor Kimball, I believe that it is good to hear and read differences in opinion on the subject of heredity.

At the past several annual meetings of the Physicians League on Epilepsy, the subject of heredity, social, medical, and economic status, and the like have been very important issues and have been discussed at great length and with considerable detail. The Physicians League on Epilepsy consists of men who have been actively engaged in the field of neurophysiology for many years. Such men as Doctor William Lennox of the Harvard Medical School, Doctor Frederic Gibbs of the University of Illinois, Doctor Robert Aird of the University of California, Doctor Russell De Jong of the University of Michigan, and many other neurophysiologists, psychiatrists, and neuropsychiatrists are active members of this organization. We have devoted ourselves primarily to the many facets which evolve around the problem of epilepsy. I make mention of this since the credence of the material in the article is not entirely acceptable. In some parts of the article there are points which Doctor Kimball stresses which are at complete divergence from all of our own experiences.

In reference to the criticism as voiced by Doctor Kimball to wit: "the present trend toward normalizing epilepsy, when the physician advises epileptics to lead a normal life, raise a family, drive cars, and forget about their illness, is the most fallacious kind of teaching yet devised . . ." it might be helpful to the Doctor to read the arguments pro and con as they were discussed by the council of the State Medical Society prior to the approval of the House of Delegates. There was nothing rash about the recommendation that well-controlled epileptics should lead normal lives with certain restrictions in employment and everyday living. It is quite universally agreed that epilepsy is a symptom complex which in no way interferes with normal thinking processes. The word "normal" in this respect would be no different than the emotional living of any human being who has a chronic-medical disorder without conceptual or perceptual disorder.

Geneticists such as Doctor Aelstron of the Institute of Genetics in Sweden and observations made by Doctor Jolly on a purely scientific genetic basis indicate that the tendency to inherit the condition is not much different than the possibilities which occur in the average population.

Apropos of epileptics driving automobiles, it is well to remember that our law in the State of Wisconsin has been in effect since 1949. There has not been any adverse experience up to the present writing. We have processed over 200 controlled epileptics for drivers' licenses and to date the experience in this matter bears out our original thesis.

In your own editorial you felt that each case should be considered "as an individual problem," with which I fully agree. I do not see how any physician could consider giving advice and treatment without considering the individual case. However, the main point of discussion is that the epileptic has a medical disorder. There is nothing more different about him than there is about any other individual who has a medical disorder which is chronic and not entirely curable but controllable. The attitude of the patient towards his disease, especially a chronic disease, which might be disabling socially has been well recognized for many years. These attitudes, however, can be altered by demonstrating that the condition may be controlled with proper medication and adequate psychotherapy.

The confusion exists in the association of the epileptic with other disabling disorders such as mental defectiveness, cerebral palsy, and other brain injuries. You must bear in mind, however, that the great majority have no other disabling difficulty. The epileptic without complications is no different mentally or physically save for his seizures than the diabetic save for his diabetic comas.

I should like to make further reference to the recent article which appeared in the current issue of the American Medical Association Journal entitled "Association of Maternal and Fetal Factors with the Development of Epilepsy," page 719, June 19, 1954. Also, I should like to make reference to a conference which I recently attended concerning itself about these very same problems. The members of this special committee, The American Physicians League on Epilepsy, consisting of representatives of all of the learned neurologic and psychiatric societies were in full agreement that the genetics of epilepsy play a very small role in the development of the condition described as epilepsy.

Very sincerely yours,
/s/ EDWARD D. SCHWADE, M. D.

Doctor Schwade has requested the publication of the following letter and comment relating to the article, "On the Inheritance of Epilepsy," which appeared in the May issue of the *Journal:*

THE NEUROLOGICAL INSTITUTE OF THE CHILDREN'S MEDICAL CENTER

300 Longwood Avenue, Boston 15, Massachusetts
The Seizure Unit

Dr. Edward D. Schwade
324 East Wisconsin Avenue
Milwaukee, Wisconsin

Dear Dr. Schwade:

I write to you as chairman of the division of Nervous and Mental Diseases of the Wisconsin Medical Society. I understand that your division was primarily responsible for the rescinding of the Wisconsin law which forbade an epileptic to marry. The righting of this injustice was a notable gain. For this leadership, epileptics and their proponents are deeply in debt to you and the physicians of Wisconsin.

However, the article by Kimball in the June issue of the Wisconsin Journal of Medicine is a contradiction of the evidence which your division must have presented to the legislature. Kimball makes the amazing statement that more than a third of the progeny of an epileptic are in danger of becoming affected. The careful reader will find that data for this statement apparently are based on that unusual person, the epileptic who already has an epileptic child. If he has two others who are normal, then of course, a third of his children are epileptic. Unfortunately, many readers do not scrutinize data critically, just as the writer of the editorial that referred to the article apparently did not.

In order to clarify matters in the minds of readers, I believe that the evidence contained in the article in question should be weighed by competent authority, preferably a geneticist, and his opinion printed in the pages of the journal.

Sincerely yours,
/s/ WILLIAM G. LENNOX, M. D.

Comment by Robert B. Aird, M. D., Associate Professor of Neurology and Neurosurgery, University of California, San Francisco:

> ". . . certainly the statistics on acquired epilepsy indicate a slight genetic factor, although the impression given in Kimball's article is that it is of no consequence. Again, and this is the most important point, I believe, the article would appear to overemphasize the "probability" of inheritance of epilepsy in cases diagnosed as belonging to the primary type."

In an effort to determine when Dr. W. H. Bayer, Merrill, joined the State Medical Society, we asked him to check his old records to see if he could verify this fact. As a result, his son, Dr. L. J. Bayer, wrote us the following letter:

> Interesting things turn up and my father, being of the old school, has them and has time and energy to ferret them out. He knew that he had all of his old cancelled checks, so he dug down to the very bottom of some drawer and there found check #25 written on January 7, 1904. It was made out to the A.M.A. in the amount of $5.00 and Dad assumes that the above amount was the dues for everything at that time. The early County Society records were turned over to some historical group in Madison a few years ago so we cannot check through them.
>
> My father states that he came to Gleason late in 1902, but was unable to attend meetings in Merrill until 1903. He said he did not own enough horses until then to get him too far from Gleason. In 1903 he became a member of the group.
>
> The above is all rather romantic, especially when I have it so very easy! We are not trying to make any fuss, for we can pay the dues, etc. This was Dad's idea and he became interested and dug back into his memoirs for want of something to do and to keep him occupied . . . a good pastime.
>
> Thank you for all the information you have sent and for taking time to look it up.

Sincerely yours,
/s/ L. J. BAYER, M. D.

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## List of Officers and Scheduled Meetings of County Medical Societies

| COUNTY | PRESIDENT | SECRETARY | MEETING DATE |
|---|---|---|---|
| Ashland-Bayfield-Iron | W. J. Tucker<br>Ashland | J. M. Jauquet<br>901 9th Ave., W.<br>Ashland | |
| Barron-Washburn-Sawyer-Burnett | W. F. Vaudreuil<br>Rice Lake | D. F. Hammond<br>Chetek | Second Tuesday<br>7:30 p.m. |
| Brown-Kewaunee-Door | G. B. Merline<br>De Pere | G. M. Shinners<br>409 E. Walnut<br>Green Bay | Second Thursday* |
| Calumet | F. P. Larme<br>New Holstein | J. M. Guthrie<br>Brillion | |
| Chippewa | C. A. Kemper<br>119½ Bridge<br>Chippewa Falls | Paul Murphy<br>Bloomer | Second Tuesday |
| Clark | K. F. Manz<br>Neillsville | J. W. Koch<br>Colby | |
| Columbia-Marquette-Adams | J. P. Harkins<br>Portage | F. W. Gissal<br>132 Washington Ave.<br>Wisconsin Dells | Every Third Month<br>7:00 p.m. |
| Crawford | R. G. Konicek<br>Prairie du Chien | H. L. Shapiro<br>Prairie du Chien | |
| Dane | S. L. Chase<br>905 University Ave.<br>Madison | G. E. Oosterhous<br>304 W. Washington<br>Madison | Second Tuesday |
| Dodge | Leonard Schrank<br>Waupun | R. F. Boock<br>119½ Front<br>Beaver Dam | Last Thursday* |
| Douglas | C. J. Picard<br>2029 E. Fifth<br>Superior | R. P. Fruehauf<br>1514 Ogden<br>Superior | First Wednesday**<br>Badger Room of the<br>Hotel Superior |
| Eau Claire-Dunn-Pepin | K. L. German<br>219 S. Barstow<br>Eau Claire | G. E. Wahl<br>616 E. Grand<br>Eau Claire | Last Monday |
| Fond du Lac | W. H. Schuler<br>Ripon | H. J. McLane<br>80 Sheboygan St.<br>Fond du Lac | Fourth Thursday* |
| Forest | O. S. Tenley<br>Wabeno | D. V. Moffet<br>Crandon | |
| Grant | E. M. Randall<br>Boscobel | H. W. Carey<br>Lancaster | Last Thursday.<br>March, June,<br>Sept. and Nov. |
| Green | N. E. Bear<br>Monroe | D. E. Mings<br>Monroe Clinic<br>Monroe | |
| Green Lake-Waushara | Russell Pelton<br>Markesan | L. S. Shemanski<br>Wautoma | Last Thursday,<br>every other month<br>starting in Jan. |
| Iowa | C. L. White<br>Mineral Point | H. M. Walker<br>Dodgeville | First Thursday<br>following<br>first Monday |
| Jefferson | E. J. Netzow<br>Lake Mills | H. N. Hunsader<br>111 S. Main<br>Fort Atkinson | Third Thursday* |

* Except June, July, and August.
** Except July and August.

## List of Officers and Scheduled Meetings of County Medical Societies—Continued

| COUNTY | PRESIDENT | SECRETARY | MEETING DATE |
|---|---|---|---|
| Juneau | J. S. Hess<br>Mauston | John E. Thompson<br>Mauston | Second Tuesday<br>Hess Clinic in<br>Mauston |
| Kenosha | Richard M. Block<br>520 58th<br>Kenosha | Helen A. Binnie<br>7609 25th<br>Kenosha | First Thursday*<br>Elks Club<br>Kenosha |
| La Crosse | C. F. Midelfort<br>1836 South Ave.<br>La Crosse | Arnold A. Cook<br>1707 Main<br>La Crosse | Third Monday |
| Lafayette | N. A. McGreane<br>128 E. Ann St.<br>Darlington | R. E. Oertley<br>Darlington | Last Tuesday |
| Langlade | M. J. Donohue<br>Antigo | F. H. Garbisch<br>Antigo | Second Wednesday |
| Lincoln | Walter Lewinnek<br>700 E. Third<br>Merrill | J. D. Millenbah<br>Merrill | |
| Manitowoc | Nelson Bonner<br>709 Washington<br>Manitowoc | W. S. Marshall<br>1522 Washington<br>Two Rivers | Last Thursday |
| Marathon | H. W. Christensen<br>501½ Third<br>Wausau | A. W. Hoessel<br>115 McIndoe<br>Wausau | |
| Marinette-Florence | Kenneth Moss<br>1554 Main<br>Marinette | R. J. Rogers<br>Oconto | Third Wednesday<br>St. Joseph's Hospital |
| Milwaukee | J. G. Garland<br>324 E. Wisconsin<br>Milwaukee | Donald M. Willson<br>324 E. Wisconsin<br>Mr. J. O. Kelley, Ex. Sec.<br>208 E. Wisconsin | Second Thursday |
| Monroe | C. E. Kozarek<br>Tomah | J. S. Mubarak<br>Tomah | Third Monday |
| Oconto | F. E. Zantow<br>Oconto | G. R. Sandgren<br>Suring | |
| Oneida-Vilas | G. R. Thuerer<br>1020 Kabel<br>Rhinelander | Marvin Wright<br>1020 Kabel<br>Rhinelander | Monthly |
| Outagamie | W. A. Adrians<br>103 W. College<br>Appleton | J. E. Gmeiner<br>103 W. College<br>Appleton | Third Thursday*<br>Elks Club<br>6:30 p.m. |
| Pierce-St. Croix | F. B. Klaas<br>East Ellsworth | P. H. Gutzler<br>River Falls | Third Tuesday |
| Polk | H. A. Dasler<br>Cornwall Clinic<br>Amery | L. J. Weller<br>Osceola | Third Thursday<br>7 p.m. |
| Portage | V. A. Benn<br>Rosholt | H. A. Anderson<br>Stevens Point | |
| Price-Taylor | E. B. Elvis<br>Medford | J. J. Leahy<br>Park Falls | Last Saturday,<br>Feb., May, Aug.,<br>and Nov. |
| Racine | G. L. Rothenmaier<br>3115 Washington Ave.<br>Racine | Eugene Pitts<br>420 Seventh<br>Racine | Third Thursday |
| Richland | W. C. Edwards<br>Richland Center | L. M. Pippin<br>Richland Center | First Tuesday<br>Richland Hospital |
| Rock | Milton Davis<br>Milton | H. M. Snodgrass<br>508 W. Milwaukee<br>Janesville | Fourth Tuesday |
| Rusk | L. M. Lundmark<br>Ladysmith | M. L. Whalen<br>Bruce | First Tuesday |
| Sauk | O. V. Pawlisch<br>Reedsburg | J. J. Rouse<br>Reedsburg | Second Tuesday* |
| Shawano | R. C. Cantwell<br>Shawano | A. J. Sebesta<br>Shawano | Third Tuesday |
| Sheboygan | J. F. Kovacic<br>925A N. Eighth<br>Sheboygan | Keith M. Keane<br>1011 N. Eighth<br>Sheboygan | First Thursday |
| Trempealeau-Jackson-Buffalo | O. M. Schneider<br>Blair | E. P. Rohde<br>Galesville | Fourth Tuesday |
| Vernon | L. F. Gulbrandsen<br>Viroqua | DeVerne W. Vig<br>Viroqua | Last Wednesday |
| Walworth | R. A. Moses<br>Delavan | Glen Smiley<br>Delavan | Second Thursday* |
| Washington-Ozaukee | T. D. Elbe<br>Thiensville | F. I. Bush<br>West Bend | Fourth Thursday |
| Waukesha | Peter Theobald<br>Oconomowoc | F. A. Thompson<br>725 American Ave.<br>Waukesha | |
| Waupaca | J. W. Monsted<br>New London | J. J. Mulvaney<br>32 S. Main<br>Clintonville | |
| Winnebago | B. S. Greenwood<br>19 Jefferson Ave.<br>Oshkosh | G. B. Hildebrand<br>216½ Main<br>Menasha | First Thursday |
| Wood | H. G. Pomainville<br>Wisconsin Rapids | N. J. Helland<br>Marshfield | Four times a year |

* Except June, July, and August.

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# The Accuracy of X-Ray Examination of the Gallbladder

By HOWARD MAUTHE, M. D.
Fond du Lac

WHILE the x-ray examination of the gallbladder is considered one of our most reliable diagnostic procedures, a critical review of technic and results should be made at frequent intervals. Such a scrutiny serves not only to reassess the validity of the test, but also to help prevent misinterpretation of the results.

This presentation is based on a study made of cholecystography at a typical general hospital* during the two-year period, January 1, 1952, to December 31, 1953. The records of all patients having cholecystectomies performed during this two-year period were obtained, and a comparison was made in each instance between the pathologic diagnosis of the specimen removed at surgery and the diagnosis made by x-ray examination. If the two diagnoses coincided, the x-ray diagnosis was considered to be correct. If not, it was called incorrect. Wherever this occurred, the record was reviewed and an attempt was made to determine the source of the error.

### Technic of Cholecystography

Telepaque in a dosage of six tablets is now routinely employed as the contrast medium. Castor oil is given five hours following the Telepaque tablets to many of the patients, especially the outpatients and those scheduled for colon examination on the same day. This procedure as demonstrated by Sengpeil[1] and Gianturco[2] greatly reduces the number of conflicting gas shadows. The following morning films are taken in the horizontal position with the use of the Bucky diaphragm. If the gallbladder is not visualized on these films, the entire examination is repeated within the next day or so. No castor oil is used for the second examination. This recheck examination is part of the gallbladder examination, and no additional charge is made. Thus, no patient is reported as having a nonvisualization of the gallbladder unless the gallbladder fails to visualize on two separate occasions. This repetition of the examination is important since approximately 3 to 5 per cent of the gallbladders which fail to visualize on the first examination will visualize at a later time.

If the gallbladder visualizes on the first two survey films, upright spot films with compression are taken of the gallbladder in several different positions. This makes it possible to demonstrate even small stones regardless of the density of the opaque material. This method of upright compression spot film radiography of the gallbladder as described by Lubert and Krause[3] has been an important contribution to gallbladder radiography. At times, the patient may be placed in Trendelenburg position during spot filming in order to eliminate gas shadows, or to observe possible motion of questionable stones. The decubitus position, although it possesses considerable merit, is difficult to employ with the type of x-ray equipment usually available. Since spot film radiography renders the use of this position almost entirely unnecessary, its use has now been abandoned in our department.

The examination is always performed under the direct control of the radiologist, and the patient is not released until a definite diagnosis is made. In all cases of nonvisualization the patient is interrogated regarding vomiting, diarrhea, or failure to follow directions; and any knowledge of disturbance in liver function is also taken into account.

The results of the examination are reported as follows:

1. "Normally functioning gallbladder with no evidence of stone." This indicates a normal gallbladder.

*St. Agnes Hospital, Fond du Lac.

2. "Normally functioning gallbladder containing nonopaque (or partially calcified) stones." This indicates a pathological gallbladder containing stones.

3. "Nonvisualization of the gallbladder. (With or without the presence of partially calcified gallstones.)" This finding, after carefully carried out double examinations and in the absence of evidence of disturbed liver function, previous cholecystectomy, etc., indicates a pathological gallbladder containing stones.

With the technic described above, it is usually unnecessary to employ such terms as "poorly functioning gallbladder," "questionable visualization of the gallbladder," etc. It should be emphasized that the term "normally functioning" as used above indicates the ability of the gallbladder to concentrate bile and only implies its ability to discharge this bile into the duodenum. Needless to say, a gallbladder which fills and concentrates bile must necessarily possess the ability to discharge it. Therefore, the use of a fat meal is of no practical value in assessing gallbladder function; and since compression spot film radiography eliminates difficulties due to dense opacification in a large gallbladder, the use of the fat meal has been discarded.

### Clinical Material Studied

Between January 1, 1952, and December 31, 1953, 235 cholecystectomies were performed at this hospital. The pathological and surgical records of these patients were reviewed, and the pathologic findings were classified. They are tabulated in Table 1. All gallbladders free from abnormality on pathologic examination and in which no stones were found were classified as normal. Cases classified as cholelithiasis with cholecystitis were those in which the gallbladder walls had inflammatory changes on histologic examination, in which stones were found either in the gallbladder or the cystic duct, or in which gallstones were known to have been present at any time. This classification includes four cases of gangrene of the gallbladder since stones were present in all of these. It also includes three cases in which stones were not found at operation but were known to have been previously present; two of these patients had had previous cholecystostomy with removal of stones, and the third had developed a fistula between the gallbladder and duodenum, with resultant gallstone ileus.

TABLE 1—*St. Agnes Hospital—January 1, 1952—December 31, 1953*

| | |
|---|---|
| Total number of cholecystomies | 235 |
| Normal gallbladder, no stones | 42 |
| Cholelithiasis with cholecystitis | 158 |
| Cholelithiasis only, no cholecystitis | 24 |
| Cholecystitis only | 8 |
| Cholesterosis | 1 |
| Carcinoma | 2 |
| Total pathological | 193 |
| Per cent pathological | 82.1 |
| Cholecystograms performed on these patients by present radiologist | 110 |

The designation, "cholelithiasis only, no cholecystitis," refers to gallbladders with stones but without histologic abnormality of the wall. The designation, "cholecystitis only," refers to those gallbladders containing no stones but which had inflammatory changes in the wall, however slight. Only eight patients fell into this category. It is not known whether these gallbladders contained stones at some time previous to surgery, but it is possible that the patients had gallstones sometime in the past.

Only two gallbladders showed carcinoma. One was metastatic, although the primary source was not identified. The other was reported as primary in the gallbladder; this gallbladder also contained stones. Of the 235 gallbladders removed, 193, or 82 per cent, were abnormal.

It is interesting to speculate on the significance of these figures with regard to the origin of gallbladder pathology. Of the 193 pathological gallbladders, only nine contained no stones. One of these patients had cholesterosis, and the other eight showed evidence of cholecystitis. It is possible that these nine patients may have had cholelithiasis at some time or other. On the other hand, 24 patients had cholelithiasis with no associated inflammatory changes. These figures suggest that in most instances the primary pathology is stone formation and that other forms of gallbladder pathology represent complications of cholelithiasis. It is therefore reasonable to assume that if the mechanism and cause of gallstone formation could be discovered and ways developed for preventing stone formation, gallbladder and bile duct surgery might become as rare as mastoidectomy has become since the advent of antibiotic drugs.

### Results

Of the 235 patients studied, 110 had cholecystography done prior to surgery in the hospital x-ray department under the present radiologist. The charts, x-ray reports, and pathologic diagnoses on these 110 patients

were compared. The results of this comparison are tabulated in Table 2, where it is seen that a total of five erroneous x-ray diagnoses were made, two normal gallbladders being called abnormal on x-ray examination and three abnormal gallbladders being called normal. An analysis of these five cases yields the following information:

*Case 93076.* X-ray diagnosis: "Very poorly functioning, probably pathologic gallbladder." Pathologic diagnosis: "Normal gallbladder." This examination was performed at the time Priodax was being used, and only one examination was done. It is probable that examination with Telepaque would have resulted in much better visualization and a "normal" diagnosis, especially with the two-examination method.

*Case 19718.* X-ray diagnosis: "Nonvisualization of the gallbladder, probable pathological gallbladder." Pathologic diagnosis: "Normal gallbladder." This examination was also done at the time when Priodax was employed, and only one examination was performed.

*Case 93077.* X-ray diagnosis: "Normally functioning gallbladder, with no evidence of stone." Pathologic diagnosis: "Cholecystitis with cholelithiasis." This examination was also performed before routine recheck examinations were being done. A review of the films shows that the gallbladder actually failed to visualize. The cause of this error was not determined.

*Case 75310.* X-ray diagnosis: "Normally functioning gallbladder with no evidence of stone." Pathologic diagnosis: Gross examination was normal. Microscopically there was a "mild infiltration of lymphocytes in the muscularis" considered as evidence of chronic cholecystitis.

*Case 57459.* X-ray diagnosis: "Normally functioning gallbladder with no evidence of stone." Pathologic diagnosis: Gross examination was normal. Microscopically there was "infiltration of the muscularis with lymphocytes" considered as evidence of chronic cholecystitis. In both this case and the one above, the pathologic changes were minimal as compared with those in typical cholecystitis. After reviewing the slides on these two patients with the pathologist, he stated he had been in doubt as to whether to call these two gallbladders normal or pathological. He finally decided there were more lymphocytes in the muscularis than are seen in normal specimens, and he therefore felt compelled to apply the diagnosis of chronic cholecystitis. In spite of this, he felt that the changes were minimal and would not have produced symptoms. After discussion we both concluded that the abnormalities found in these two gallbladders were not surgically significant. The two cases are included as errors because of the standards set up at the beginning of this study, but I am inclined to question the wisdom of the removal of these two gallbladders; and I believe the x-ray diagnosis of normal gallbladder was actually correct. This leaves us with only one error in the diagnosis of abnormal gallbladders.

TABLE 2—*Analysis of 110 Gallbladders Examined and Removed, 1952 through 1953*

| Pathologic Diagnosis | | X-Ray Diagnosis Normal | X-Ray Diagnosis Abnormal |
|---|---|---|---|
| Normal gallbladder | 13 | 11 | 2 |
| Cholelithiasis with cholecystitis | 77 | 1 | 76 |
| Cholelithiasis only | 12 | 0 | 12 |
| Cholecystitis only | 6 | 2 | 4 |
| Primary carcinoma | 1 | 0 | 1 |
| Metastatic carcinoma | 1 | 0 | 1 |
| Total | 110 | | |
| Number correct x-ray diagnoses | 105 | | |
| Per cent correct x-ray diagnoses | 95.5% | | |

Viewed in the light of the discussion above, it is seen that the cholecystographic method actually was without significant error when applied to the pathological gallbladder. The method practically never fails to reveal pathology when it is present. On the other hand, it is inevitable that a certain number of normal gallbladders will fail to visualize on x-ray examination because of poor liver function, jaundice, or other factors. Therefore, some error will occur when the method is applied to the normal gallbladder.

The implication of these considerations to the surgeon is important. A few normal gallbladders will probably be removed from time to time as a result of their failure to visualize on x-ray examination in patients who have clinical symptoms pointing to gallbladder disease. On the other hand, to proceed with a cholecystectomy in the face of normal x-ray findings in the gallbladder examination is an action which is difficult to justify, if indeed it can be defended at all.

The experience recounted here is certainly not unique, and results of comparable accuracy are obtained in any well-run x-ray department. In spite of this, a peculiar idea persists in some quarters that the x-ray diagnosis of a normal gallbladder is somehow unreliable and that if the patient's symptoms strongly suggest gallbladder disease, the gallbladder should be removed in spite of the fact that it is normal on x-ray examination. Sometimes such an ill-advised cholecystectomy is performed without even the most cursory investigation of other possible causes of the patient's symptoms. Patients in whom the physician suspects gallbladder disease, and whose cholecystograms are normal should have careful investigation of the stomach, colon, and urinary tract. In fact, before cholecystectomy is undertaken, examination of the rest of the gastrointestinal tract should be performed regardless of the findings at cholecystography. Nonvisualization of the gallbladder may be produced by duodenal ulcer with surrounding inflammatory reaction, by carcinoma contiguous to the common duct, and by other conditions. Furthermore, some patients have pathological gallbladders which are asymptomatic. Their complaints are due to other coexisting disease. It is well for the surgeon to have the best knowledge possible regarding these factors before undertaking operation. If proper attention is given to the x-ray findings in patients with possible gallbladder disease, the number of normal gallbladders removed will be reduced to a small figure.


## Summary

1. A simple method of evaluating the accuracy of cholecystography is described.

2. With ordinary care in cholecystographic technic, a degree of accuracy of over 95 per cent can be achieved in the ordinary general hospital or radiologist's office.

3. Because of the many factors upon which normal gallbladder visualization depends, cholecystography may occasionally indicate the presence of gallbladder disease where no disease actually exists.

4. Normal cholecystograms are practically never obtained in the presence of significant gallbladder disease—stones, carcinoma, or surgically significant cholecystitis.

5. Cholecystectomy in a patient whose cholecystogram is normal is not justified. Even with an abnormal cholecystogram, it is wise to examine the other parts of the gastrointestinal tract before cholecystectomy is done.

6. The formation of stones appears to be the primary pathology in the gallbladder, and cholecystitis is probably the result of cholelithiasis instead of the cause of it.


252 Sheboygan Street.

### REFERENCES


1. Sengpeil, G. W.: Compatibility of castor oil and Priodax in concurrent examination of colon and gallbladder, Radiology 53:75–79 (July) 1949.
2. Gianturco, C.: Fast radiological visceral survey, Radiology 54:59–63 (Jan.) 1950.
3. Lubert, M., and Krause, G. R.: Upright cholecystography using the fluoroscopic spot-filmer with graded compression, Radiology 61:879–884 (Dec.) 1953.


## MILWAUKEE PSYCHOSOMATIC FORUM TO HOLD FIRST MEETING

The first meeting of the Milwaukee Psychosomatic Forum will be held on Wednesday, October 13, in Milwaukee at the Elks Club at 7:30 p.m.

The meeting will be a panel discussion on "Physician Patient Relationship." The moderator will be Dr. John Hirschboeck, and the panel will consist of Drs. M. C. Lindert, Carl Eberbach, Zachary Slomovitz, Samuel Black, and R. A. Jefferson. The members of the panel will be prepared to answer questions from the floor. All physicians are welcome to attend.

## BOARD OF MEDICAL EXAMINERS ANNOUNCES FALL RECIPROCITY MEETING

October 15 is the date that has been set by the State Board of Medical Examiners for its special fall reciprocity meeting.

The meeting will be conducted on the eleventh floor of the State Office Building, Madison; and the Board will consider applications for license by reciprocity.

# Mycetoma—Report of a Case Due to Monosporium Apiospermum in a Native of Minnesota

By ROBERT S. HAUKOHL, M. D., and HARRY B. SADOFF, M. D.
Milwaukee

MYCETOMA is a chronic granulomatous inflammatory process usually affecting the feet. Rarely, it may also affect other portions of the body. The disease is caused by a variety of fungi, all of which give rise to an essentially similar clinical and pathological picture. Although the disease has been known for centuries, it was first separated as a clinical entity in 1842 by Gill, who worked in the city of Madura, India. The term "Madura foot" was first applied by Colebrook[1] in 1846. The fungus etiology of the disease was established by Van Dyke Carter[2] in 1860.

Cases have been reported from all continents but Australia and from most countries of the world. Up to 1949, forty-nine cases had been reported in the United States,[3] the majority from Texas, California, and Arizona. Six previous cases have been seen in north central United States, one each in Wisconsin,[4] Minnesota,[5] Iowa,[6] and Ohio,[7] and two cases in Indiana.[8,9] The previous case of mycetoma reported from Minnesota by Thompson and Ikeda[5] was apparently contracted in Texas and was due to a unique organism, *Madurella ikedai*. *Monosporium apiospermum*, the imperfect stage of *Allescheria boydii*,[10] was cultured from the patient herein reported; this is the twenty-sixth instance in the world literature[11] in which this organism has been shown to cause mycetoma. The case is detailed not only because of its rarity but also to call attention once again to the entity which assuredly must occur with greater frequency than the reports in the literature would indicate and to emphasize the use of stilbamidine in therapy.

## Case Summary

J. P., a single white male, age 20, was first seen by one of us (H. B. S.) on March 7, 1953, because of pain and swelling of the left ankle, with intermittent drainage from a number of sinuses in the region. He was unable to wear a shoe comfortably. He was a native of Warren, Minnesota, where he worked on a farm. He stated that, at least as a youth, it was customary not to wear shoes and that minor injuries of the feet, particularly from clover stubble, were common. In October of 1951 he sustained a puncture wound from flax stubble, which resulted in a draining sinus that later healed spontaneously. During the following year and one-half, a number of additional sinuses developed; and the involved area increased in size and finally began to extend onto the dorsum of the foot. There was no other pertinent history.

Physical examination was entirely negative except for the findings on the left foot and ankle. A firm, doughy, fixed, elongated soft tissue mass was present in the region of the medial malleolus and extended onto the dorsum of the foot. This was acutely tender, and the overlying skin was reddened. A number of closed sinus scars were seen. There was no apparent involvement of the joints, although the patient walked with a slight limp.

Roentgen examination of the foot and ankle in various projections revealed only a homogeneous soft tissue mass in the region of the medial malleolus. The osseous structures were normal.

Results of routine laboratory work and a chest fluororoentgenogram were normal.

The patient was admitted to Evangelical Deaconess Hospital, Milwaukee, on April 11, 1953, with a provisional diagnosis of infectious granuloma of the left ankle. The following day the ankle was surgically explored.

The mass was found to be adherent to the skin and underlying ligaments and fascia. It was partially removed, piecemeal, in numerous irregular cartilaginous and friable masses of bluish-gray tissue.

The patient was placed on prophylactic combiotic, 0.5 Gm. twice a day; and the operative wound healed by primary intention. He was discharged on April 20, 1953.

The operative specimen consisted of five irregular masses of rubbery and fibrous gray tissue ranging from 1 cm. to 2.5 cm. in maximum diameter. When the tissue was sec-

tioned, numerous very tiny yellow and amber colored soft areas were seen within an opaque gray fibrous matrix.

Microscopic examination revealed a granulomatous inflammatory process within an abundant collagenous connective tissue matrix. The granulomas were composed peripherally of proliferating connective tissue densely infiltrated by lymphocytes and large mononuclear cells. No typical epithelioid cells were found, and only rare multinucleated giant cells were seen. The central zone consisted of a micro-abscess with an accumulation of neutrophils. Many of these also contained small fungus colonies that were stained basophilic centrally and acidophilic peripherally with hematoxylin and eosin (Fig. 1). Radiating, coarse, septate branched mycelia could be made out with routine staining. This, however, was better demonstrated by the Schiff technic, with which numerous small ovoid spores could also be demonstrated at the periphery (Fig. 2). The organism was demonstrated to be gram positive and non acid-fast. The lesion was diagnosed as "compatible with maduromycosis."

Before the patient was discharged from the hospital, a small amount of serum was aspirated from the operative site and from the undisturbed soft tissue swelling on the dorsum of the foot. This material was inoculated on a variety of media including blood agar, Littman's oxgall agar (with added streptomycin), Sabouraud, and thioglycollate medium. Within a week a luxuriant mycelial growth was noted on all media but the thioglycollate. The colonies at first were discrete, round, convex, and cottony but after three to four weeks developed buff colored centers with white cottony edges (Fig. 3). Potato agar slide cultures and wet mounts showed broad, branching septate hyphae with numerous oval or pear-shaped

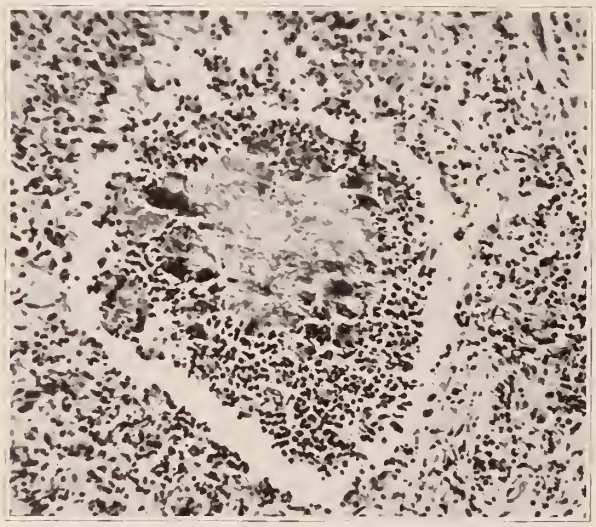

Fig. 1—Histologic section of tissue removed from ankle, showing a micro-abscess containing a colony of *Monosporium apiospermum*. Stained with hematoxylin and eosin. (130 X)

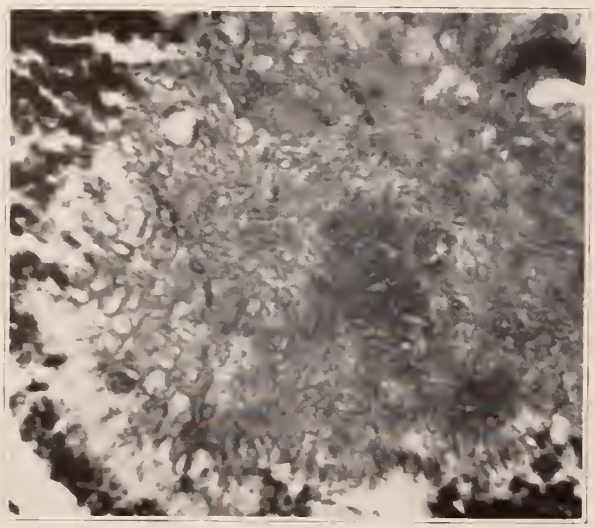

Fig. 2—Colony of *Monosporium apiospermum* showing characteristic ovoid spores and radiating mycelia. Demonstrated by use of Schiff technic (385 X).

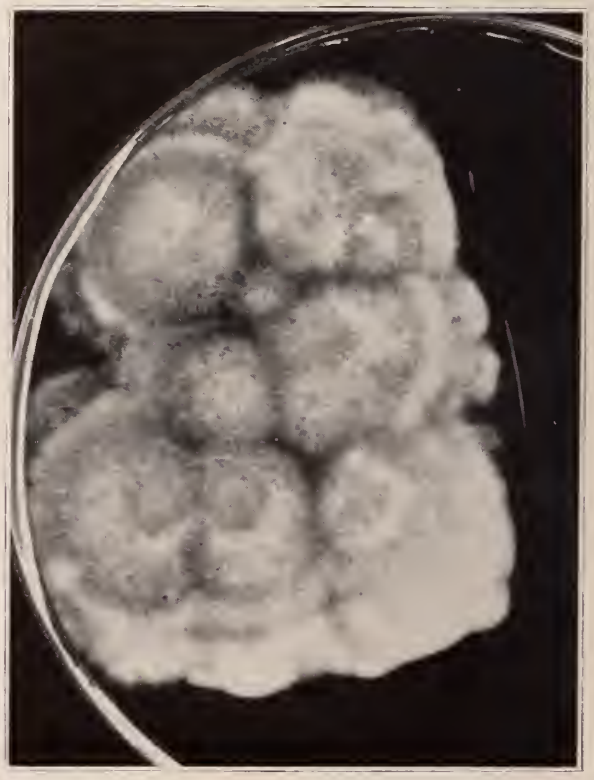

Fig. 3—Giant colonies of *Monosporium apiospermum* after four weeks on Littman's oxgall medium with added streptomycin. The cottony periphery and buff colored center are characteristic.

conidia, 6 to 7 micra in diameter, arising by short conidiophores from the sides of the hyphae or terminally on long conidiophores.

The organism was identified as *Monosporium apiospermum*. This was confirmed by Dr. Libero Ajello[12] of the U. S. Public Health Communicable Disease Laboratory, Chamblee, Georgia. On the suggestion of Dr. Ajello, the patient was readmitted to the hospital for the administration of stilbamidine intravenously. He was given 150 mg. diluted in 200 cc. of sterile isotonic sodium chloride on June 20, 1953, and a similar dosage on June 27, 1953, without untoward systemic reaction.

The patient shortly thereafter returned to Minnesota. A report from his local physician states that seven months after discharge the local tissue swelling had entirely disappeared and that roentgenograms of the ankle showed no osseous involvement. This period of time, however, is much too short for evaluation of therapy.

## Summary

A case of mycetoma pedis in a native of Minnesota is reported. The case was due to *Monosporium apiospermum*.

(R.S.H.) 1821 West Wisconsin Avenue.

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## ANNUAL MEETING, WISCONSIN CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

### October 3, 1954, Schroeder Hotel, Milwaukee, Wisconsin

1:00 P. M. Foyer, Fifth Floor: Scientific Exhibits and Registration

2:00 P. M. East Room: Scientific Program

1. "The Differential Diagnosis of Carcinoma of the Lung," Herman J. Moersch, M. D., Rochester, Minnesota
2. "Management of Cardiac Emergencies," Howard L. Correll, M. D., Milwaukee, Wisconsin
3. "Recent Advances in Inhalation Therapy in Bronchopulmonary Diseases," Edwin R. Levine, M. D., Chicago, Illinois
4. "Benign Tumors of the Chest," William M. Lees, M. D., Chicago, Illinois
5. "Clinical Aspects of Hypertension of the Greater and Lesser Circulation," Charles W. Crumpton, M. D., Madison, Wisconsin

# Industrial Health Services and the Private Practitioner

By JOHN ALLEN, M. D.*
Madison

AS ONE active in the dual capacity of private practitioner and industrial health consultant, it is my desire to point out some of the present objectives of medicine in industry and how these objectives affect the private physician. Industrial medicine is continually striving to conserve the health of the worker and to promote a broader understanding of the purpose of medical care for employees.

Business in the United States is endeavoring to increase its operating efficiency, reduce overhead, and streamline production methods. Any such objective must be intimately concerned with the health of the worker. It is understandable, therefore, that medical service in industry is a subject of growing concern to management, to labor, and to the practicing physician.

In years gone by, disabling and disfiguring accidents were almost expected as being necessary for progress. This is not so any more. Now through highly effective safety programs, improved engineering methods, and participation by other interested groups supported by both management and labor, occupational accidents and illness have been greatly reduced. Large teaching and research programs are always in progress to achieve ways to improve the health of the worker.

Occupational medicine has been defined as that field of practice which deals with medical problems that are caused or aggravated by factors of employment. Physicians serve industry in one of several ways: as practitioners who provide services in their own offices to employees or employers; as examiners in the employ of bureaus or insurance carriers; or as in-plant physicians on a full-time, part-time, or on-call basis.

Many modern in-plant medical departments now include the work of nurses, engineers, safety personnel, hygienists, and psychologists. To such a department, the term "health service" has been aptly applied. In addition to giving medical and surgical treatment, the industrial health service is concerned with the broad application of measures of prevention and health maintenance.

The industrial medical service will be specifically adapted to the needs of the particular industry it serves. Thus, it may be the principal medical service of an isolated community, such as in certain coal mining areas, or it may be a part of a medical care program which is operating in a large metropolitan area and medical center, such as in Madison.

Services offered by industrial medical programs vary from the minimum first aid stations to the most elaborate diagnostic and treatment centers. However, the following services will be found in most industrial medical departments: treatment of occupationally incurred injuries or illnesses, consultation and minor treatment for nonoccupational conditions, pre-employment examinations, post-sickness absence examinations, and special examinations to determine occupational disease or hazards.

In line with the current philosophy of consideration of a patient as a whole, it must be remembered that a considerable portion of the experiences of most adults is job related. The full meaning of the components to the whole can be effectively considered only when there are good health services within the plant, as well as without, and when there is good communication between the people who provide the two kinds of service. Without such a well-rounded grasp of the total problems of workers, both in-plant and outside medical services will suffer a loss of efficiency.

Just as specialists are needed in the variety of medical and surgical fields, so are they needed in industry. The industrial physicians, by their close association with the work shop, are able to effectively evaluate the effect of employment on the individual and on the group. The private physician cannot be expected to be familiar with the work situation of each of his patients, yet this information can be very important to the favorable outcome of a symptom complex under treatment by the family doctor.

* Medical Consultant, Oscar Mayer and Company.

Present-day industrial practice is good clinical medicine. To the industrial physician, the worker is regarded as a whole man with both individual and group reaction to his work, to accidents and illness, and to the immediate environment of the work situation, as well as to the community and his family.

The industrial physician is often sought by the employee for counsel and guidance in general health problems beyond those of an occupational nature. This provides an opportunity to encourage the employee to seek prompt medical care from his family physician. Frequently such prompting leads to early diagnosis, shorter disability, and reduced economic loss. The family physician, by his contact with the industrial physician, is provided with professional information needed to insure medical care designed to return the worker to useful productivity at the earliest time.

The success of medical service in industry depends largely upon four factors: 1. The sympathetic and genuine interest of top management, 2. The wholehearted cooperation of employees, 3. A competent and impartial medical staff in whom both management and employees have complete confidence, and 4. A complete understanding of health services in industry by all members of the medical profession and close cooperation between the inplant and the outside medical services.

Management is charged with the responsibility to protect its employees against hazards to health and harmful work situations. Measures of this type are not a matter of choice but are essential duties. In addition, management has a right to provide additional medical and health services for promoting efficiency and industrial production. The purpose of medical service in industry is to maintain health, not to make money. Any financial gain is essentially a by-product.

An adequate medical program benefits the employer through better job placement, a healthy working force, and proper use of handicapped individuals. The employee benefits because the program assures proper job placement, provides him information about his physical condition, increases the period of gainful employment, and prevents development of disabling diseases. Thus, the industrial physician and the private practitioner working closely together share a most important part in safeguarding the health of our country's work force.

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2805 East Washington Avenue.

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## UNIVERSITY OF MINNESOTA SCHEDULES CONTINUATION COURSES

The University of Minnesota has announced the following continuation courses to be held during October and November. All of the courses are to be held at the Center for Continuation Study on the University of Minnesota campus.

**October 14–16—The Use of the Minnesota Multiphasic Inventory (MMPI)**

The course is intended primarily for clinical psychologists but will also be open to psychiatrists and other physicians interested in the use of the MMPI.

*Guest faculty will include:* Doctors George Welsh, Associate Professor, Department of Clinical Psychology, University of North Carolina, and Harrison Gough, Assistant Professor, Department of Psychology, University of California.

*Under direction of:* Dr. Starke R. Hathaway, Professor and Director, Division of Clinical Psychology.

**October 28–30—Dermatology for Specialists**

The program will deal with topics of current interest to practicing dermatologists, with special emphasis being placed on sarcoidosis.

*Under direction of:* Dr. Henry E. Michelson, Professor, Department of Medicine, and Director, Division of Dermatology.

**November 4–6—Anesthesiology for General Physicians**

The course will deal with all types of anesthetic technics, including those used in obstetrics. Newer anesthetic agents will be discussed.

*Under direction of:* Dr. Frederick H. Van Bergen, Associate Professor and Acting Director, Division of Anesthesiology.

# Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

## REPORT OF A CASE*

This 50-year-old male was admitted to the hospital because of hematuria for one day. On March 1, 1954, he had an upper respiratory infection, with marked nasal obstruction; and he consulted two ear, nose, and throat men. A week later he noted dark bloody urine for several days. This disappeared, but the urine remained cloudy until the final episode of hematuria. There was no dysuria, frequency or nocturia, ankle edema, headache, vomiting, diarrhea, or melena. He complained of a chilly sensation, with nocturnal perspiration and fever on two occasions, and an eight pound weight loss in the past two weeks. Urinalysis during a two-day hospitalization in 1940 for "singultus" revealed specific gravity, 1.023; albumin, trace; sugar, negative; microscopic, many granular and hyaline casts; 1 to 4 white blood cells, and 2 to 3 red blood cells per high power field. He had "left renal colic" one year before without hematuria or cloudy urine; this apparently responded to conservative management. He had a nasal plastic operation one year ago. The patient was investigated in 1952 because of a suspicious survey chest x-ray (guinea pig inoculation and culture negative for tuberculosis, sedimentation rate 6 mm. per hour). There was no family history of tuberculosis, carcinoma, or diabetes. The history by systems and social history were negative.

*Physical Examination:* Temperature, 99.2 F.; pulse, 70; respiration, 16; blood pressure, 120/70. *General:* Well-developed, well-nourished white male, alert and cooperative. *Skin:* Color and turgor normal. *Head:* Negative. *Neck:* No masses. *Eyes:* Reflexes normal, extraocular movements normal, pupils round and equal, eyegrounds normal. *Nose:* Congested and obstructed because of mucous membrane edema. *Chest:* Symmetrical, no nodes. *Lungs:* Clear to percussion and auscultation, no rales, breath sounds normal. *Heart:* Rate and rhythm normal, tones good quality, no murmurs. *Abdomen:* Soft, no distention, tenderness, palpable organs or masses, bowel sounds present, no costovertebral angle tenderness. *Extremities:* No edema, varicosities. *Neurological:* Normal. *Rectal:* Negative.

*Admission Laboratory Examination: Urine:* Cloudy; amber; acid; specific gravity, 1.020; albumin, 3+; sugar, negative; microscopic, packed with red blood cells, 10 to 15 granular casts per low power field. *Kline:* Negative. *Blood:* Hemoglobin, 12 Gm. (78 per cent); red blood cell count, 4,000,000; white blood cell count, 11,200; platelet count, 207,000. Differential count, segmented, 74 per cent; bands, 2 per cent; lymphocytes, 21 per cent; monocytes, 2 per cent; eosinophils, 1 per cent. *Sedimentation Rate* (Westergren): 102 mm. per hour. *Prothrombin Time* (Quick): 19 seconds (50 per cent). *Nonprotein Nitrogen:* 47.5 mg. per cent.

*Subsequent Laboratory Examination: Urine:* Essentially unchanged; specific gravity, 1.005 to 1.022. *Blood:* Progressive drop of hemoglobin and red count to March 31. Hemoglobin, 7.5 Gm. (48 per cent); red blood cell count, 2,560,000; white blood cell count rose to 34,400 on March 31. Platelets fluctuated between 93,000 and 237,000. Nonprotein nitrogen rose to 108 mg. per cent on March 26 and then fell to 85.5 mg. per cent on March 28. *Total Protein, March 22:* 5.84 Gm. per cent. *Albumin-Globulin Ratio:* 1.6/1. *Bilirubin, March 27:* 1 minute, .2 mg. per cent; 30 minutes, .8 mg. per cent. *Guinea Pig Inoculation and Cultures of Urine for Tuberculosis:* Negative. *Urine, March 24:* Negative for porphyrins. *Stool, March 27:* Negative for blood. *Antistreptolysin titer, March 30:* Less than 50 units. *Tuberculin test:* Doubtful positive.

*Course in Hospital:* It was demonstrated that the hematuria was coming from both kidneys and that there was diffuse capillary nasal bleeding. The patient was treated with combiotic and sulfadiazine during the first two days of admission. On March 25, bilateral subconjunctival hemorrhages were noted. On March 26, a Rumpel–Leede test

* From the Departments of Pathology, Marquette University School of Medicine and Deaconess Hospital, Milwaukee.

was negative. The blood pressure remained normal at 130/70. The urinary output was poorly recorded but apparently varied from 500 to 1,500 cc. per day. The patient ran a low-grade fever throughout hospitalization and on occasion complained of pain in the shoulders and wrists. His general condition deteriorated day by day, and on March 31 he developed a cough productive of bloody sputum. The amount of blood in the sputum increased until a massive pulmonary hemorrhage occurred; and in spite of emergency treatment, he expired.

**Dr. A. Melamed** (Radiologist): The first films on this patient were taken in July 1952 as a result of an abnormal survey film. Our studies showed nothing of significance. There was no evidence of an active tuberculous lesion. The hila were normal, the heart shadow was not enlarged, and the costophrenic angles were clear.

When the patient entered the hospital, another series of x-ray films showed a change in appearance of the right apex in the form of a diffuse haziness or clouding. The left apex was perfectly clear. The chest was, therefore, investigated further by means of Bucky films, which failed to disclose any abnormality in the osseous structures. We were attempting to show the presence of some destructive lesion in the nature of a superior sulcus tumor. Sectional radiography showed more clearly the mass or shadow of increased density in the apical portion of the right lung field. The lower border of this shadow seemed to be somewhat convex.

Angiocardiography was performed and that failed to show any alteration of the vascular pattern either in the arterial system or in the large veins going into the heart. It was, therefore, our impression that this lesion was pleural and/or parenchymal. The etiology was not certain.

The urinary tract was investigated by means of intravenous and retrograde pyelography. There was no abnormality on the right side. On the left there was a questionable deformity of one or more of the calyces in the lower pole region. It was our impression, however, that the findings were within the limits of normal and that these calyces were visualized at different angles, simulating pressure deformities.

**Dr. Sennett** (Internist): This 50-year-old white male presents a very interesting picture of hematuria, epistaxis, subconjunctival hemorrhage, and hemoptysis. Examination of the protocol revealed that the admitting complaint was that of hematuria. The first consultant, called in because of the hematuria, was a urologist, who on cystoscopy discovered that the bladder was negative and that blood was emanating from both ureters. Retrograde pyelograms were done at this time, and the kidneys were found to be radiologically normal. At this time, samples of urine were taken from each ureter and subjected to guinea pig inoculation and culture for tuberculosis, which subsequently proved to be negative. Thus, at one sweep, for practical purposes, we were able to rule out the possibility of neoplastic disease and tuberculosis of the kidneys. It is stated that it is not unusual to get negative cultures of tuberculous urine; however, to further dismiss the possibility of tuberculosis so far as the kidneys are concerned, it is reported that the tuberculin test was a doubtful positive. Furthermore, it is well to keep in mind that in cases of far advanced disease of the kidneys by tuberculosis, one frequently finds evidence of spread to the bladder, associated with symptoms of cystitis, which are lacking in this case.

Some other diseases of the kidney might be considered if we have ruled out carcinoma and tuberculosis. Might we be dealing with pyelonephritis? I do not believe so because of the absence of genuine clinical sepsis and the absence of pyuria and the symptoms of cystitis. Might this patient have had bilateral renal stones giving rise to the hematuria? Perhaps. The history of left renal colic of a year ago would be compatible; but in view of subsequent findings and the negative pyelogram, I believe that nephrolithiasis need not be too seriously considered.

Might this patient's hematuria be a manifestation of a blood dyscrasia? In the case of hematuria, it is well to think of such a possibility in the differential diagnosis. Certainly in view of the subsequent events, this is a very serious consideration. Under this heading, one must keep in mind the hemorrhagic diseases, such as hemophilia and the hemophiloid states. The various types of purpura, such as thrombocytopenic purpura, scurvy, hypoprothrombinemia, and the Henoch-Schönlein syndrome, must be considered. We may deal with this group rather quickly except for the last-named syndrome. I think we may satisfactorily rule out hemophilia and the hemophiloid states on the basis of the

normal bleeding and clotting times and the negative Rumpel–Leede test; and hypoprothrombinemia does not appear to be present because of the relatively high level of prothrombin activity. The thrombocytopenic state may adequately be dismissed in view of the relatively normal platelet counts and the definitely normal clot retraction times. In so far as purpura is concerned, we are left with the consideration of an allergic purpura; namely, the Henoch–Schönlein syndrome. This syndrome usually presents itself with bleeding into the gastrointestinal tract and/or the joints. More often than not, it occurs in younger people and is recurrent. Although fatalities have been reported, they are unusual. Nevertheless, instances of bleeding into organs other than the gastrointestinal tract and the joints may occur, and therefore one will have to keep in mind the possibility that in this particular case we may be dealing with the Henoch-Schönlein syndrome.

Then there is the syndrome known as hereditary hemorrhagic telangiectasia (Rendu-Osler–Weber syndrome) in which bleeding may ensue from the nose, mouth, lungs, gastrointestinal tract, kidneys, etc. The most common site of bleeding in this situation is the mucous membrane of the nose and the mouth. One very often sees the tiny spider-like telangiectatic spots from which the bleeding emanates. Here, too, all the tests for defects of bleeding and clotting are normal. The disease apparently occurs more often in males and is definitely sex linked. So far as we know, in the case under discussion no telangiectasia was ever described, nor was the patient's family history suggestive in this direction. However, it must be admitted that the bleeding in this case may be a manifestation of hereditary hemorrhagic telangiectasia.

Finally, having dismissed by exclusion or ignorance some of the more rare or exotic conditions, we must return to the more prosaic disease, certainly at least on the basis of frequency. Thus, on the basis of frequency, one comes head on with the possibility of this patient having had, at least at the onset, acute glomerulonephritis. Certainly this is possible in view of the fact that some fourteen years previously, on an admission for singultus, an incidental examination of the urine revealed many casts. We note that his urine remained bloody throughout his hospitalization, that the nonprotein nitrogen was moderately elevated, that he had four plus albumin in his urine consistently, all of which are compatible with such a diagnosis. We also are informed that there were no changes in his eye grounds, there was no peripheral swelling, and that he had no hypertension. This latter group of signs is frequently associated with acute nephritis; however, its absence does not rule out the possibility. As a matter of fact, we almost have to accept this diagnosis so far as the renal lesion is concerned on the basis of exclusion of the previously discussed situations. The difficulty that presented itself to me was not so much the glomerulonephritis but rather trying to correlate the various manifestations of hemorrhage. This could easily be done if there were a blood dyscrasia, but I do not feel that a blood dyscrasia is responsible. This might also be fairly well acceptable if it were due to a Rendu–Osler–Weber syndrome; however, I do not feel this was responsible. This conceivably might be the Henoch–Schönlein syndrome; but on the basis of no blood in the stool or active bleeding into the joints, I am extremely hesitant about invoking this diagnosis. Therefore, in trying to put together all the assorted facts, I arrived at a situation which, correctly or incorrectly, must be considered a basic generalized disease. A lesion which would give rise to bleeding in many and separate areas of the body, which occurs in a relatively short space of time, and which is not on the basis of a blood dyscrasia or coagulation defect, must, therefore, be on the basis of a defect of the small blood vessels.

Under the heading of small blood vessel diseases come a variety of conditions, many of them loosely related to the collagen disease group and others perhaps indirectly or distantly related to this group. I have reference to diseases such as periarteritis nodosa, disseminated lupus erythematosus, acute rheumatic fever, etc. Certainly it is conceivable that much of what has happened in this case might be explained on the basis of periarteritis nodosa. I do not believe that we are dealing with disseminated lupus because of the absence of lesions on the face, the absence of leukopenia, and the fact that the sex is wrong from a statistical point of view. Rheumatic fever in itself is a very distant possibility and must be considered in this case because of the very rapid sedimentation rate and the complaint of pain in the pa-

Figure 1

tient's shoulders and wrists, associated with swelling of his right arm and wrist. Hemoptysis is an infrequent but possible complication of rheumatic pneumonitis; however, hematuria is even more unusual.

Finally, one comes to that group of diseases in which there is involvement of all the small blood vessels, particularly the small arteries, secondary to an allergic or hypersensitivity phenomenon which some have called acute necrotizing angiitis. In this condition, many organ systems are involved, each having the common denominator of acute necrosis of the small arteries, sometimes including the small veins and involving the capillaries. Under such a circumstance it is easy to understand how hemorrhage may occur in any organ system as it occurred in this patient. Thus, we are able to explain the continued bleeding into the kidneys, the epistaxis, the hemoptysis, the conjunctival hemorrhages, and even those minor episodes of blood appearing once upon vomiting and slightly on one bowel movement. In retrospect, it probably is fair to say that the patient had glomerulonephritis previously on the basis of the history of casts in his urine 14 years ago and that at the time of his last admission be had an acute exacerbation of a latent low-grade glomerulonephritis. Characteristically, one often finds evidence of old healed necrotic lesions with other lesions in the acute necrotic stage. These individuals are usually affected with uremia. In this particular case, we have azotemia; but we do not have clinical uremia. In connection with this diagnosis, one can then turn his attention to the therapy the patient has received in view of the fact that many of these conditions are aggravated, if not precipitated, by the use of sulfonamide preparations and/or penicillin. We know for a fact that this patient received a penicillin containing antibiotic preparation and sulfadiazine at the hospital and very possibly received either penicillin and/or sulfa by the ear, nose, and throat physicians who treated him for his upper respiratory infection just before the onset of his hematuria. It is conceivable, although not likely, that the event of epistaxis and hemoptysis might not have occurred had the penicillin and sulfadiazine been withheld at the time of the patient's admission to the hospital. It is also conceivable, although not likely, that the hematuria alone might possibly have subsided.

Figure 2

During the review of this patient's chart in preparing this presentation, I was perplexed by the continual references the patient made to pain in his shoulder. However, I feel that on the basis of involvement of the smaller arteries and on the basis of necrosis, or perhaps actual periarteritis nodosa, that the explanation is available. Cases have been reported, and I would not be surprised if such were the case here, of an arteriolitis on the basis of hypersensitivity associated with periarteritis nodosa and perhaps some of the lesions resembling acute rheumatic fever. We might also find evidence of acute glomerulonephritis associated with crescents in the glomeruli indicative of subacute glomerulonephritis.

Finally, in regard to the abnormal chest x-ray which was of great concern to everybody including myself in reviewing the rec-

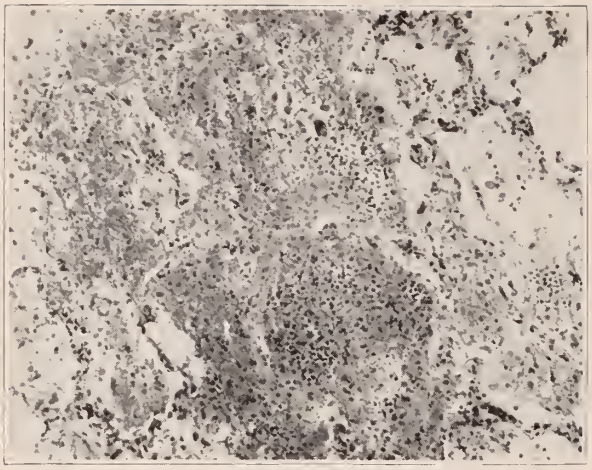

Figure 3

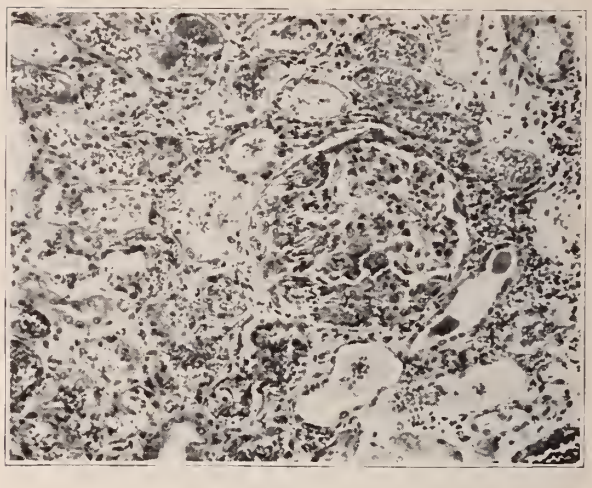

Figure 4

ord, we shall turn to one of the consultants who saw the patient in regard to his chest condition. This consultant properly advised the taking of special x-ray views, which was done, and further advised the possibility of doing bronchoscopy, which was not done, and possibly resecting a paratracheal fat pad. As I stated previously, I do not believe this lesion to be tuberculosis of a recent date, in view of the negative guinea pig and culture examination, and in view of the very doubtful positive tuberculin test. I don't see this as a tumor or cancer of the lung giving rise to the hemorrhagic manifestations in this case. However, because of the sudden appearance of the lesion, something must have taken place. We do not know what this condition is; however, I would suggest the possibility that we may be dealing with a subpleural hematoma on the basis of what we have discussed hereto.

In summary, therefore, and on the basis of the clinical record and the data presented, I believe that we are dealing with a case in which there was an acute glomerulonephritis, associated with a necrotizing angiitis of the nasal mucosa, the conjunctivae, and the pulmonary parenchyma. I should not be at all surprised if lesions in various stages were to be found over the entire body, including the muscles and possibly the heart. Finally, it is entirely possible that this entire series of events was precipitated by the unfortunate use of penicillin or sulfonamides or both, although it is entirely possible that it may have occurred on the basis of a hypersensitivity reaction to infection.

**Dr. Haukohl** (Pathologist): The important gross autopsy findings in this case were confined to the lungs and to the kidneys, although a few petechiae were found elsewhere. The kidneys were very markedly enlarged and their capsules stripped away easily, revealing deeply congested external surfaces in innumerable tiny petechial hemorrhages. The cut surface showed deep red-brown pigmentation of the papillae and collecting tubules and rather marked hemorrhagic stippling of the swollen cortex. (Fig. 1). There were one or two small petechial hemorrhages in the renal pelvis and in the urinary bladder. We found only one or two scattered petechiae in the gastrointestinal tract. At the time of autopsy, there were diffuse bilateral conjunctival hemorrhages.

The lungs showed diffuse pulmonary edema and massive bilateral hemorrhage. (Fig. 2). This hemorrhage, however, did not appear to arise from a mass present in the right apex which was adherent to the parietal and visceral pleura. On section, this had a caseous center and a fibrotic periphery. Histologically, it was a caseous granuloma compatible with a tuberculoma, although tubercle bacilli were not demonstrable by special staining methods. Elsewhere the lungs showed massive intra-alveolar accumulation of blood with a diffuse necrotizing alveolitis. (Fig. 3).

The kidneys showed a diffuse hemorrhagic glomerulonephritis of fairly recent origin. I am unable to explain the urinalysis findings in 1940, unless the patient had another attack of glomerulonephritis which healed. The renal lesion at this time appeared to be fairly acute and of a proliferative type, with many capsular crescents and focal fibrinoid

necrosis of the capillary loops. The spaces of Bowman were completely filled with blood and the distal tubules filled with blood and hemoglobin. (Fig. 4).

Dr. Jesse Edwards of the Mayo Clinic has recently described a number of similar cases and has called attention to an unusual lesion of the pulmonary alveolar walls. He reported seven cases of what has been called necrotizing pulmonary alveolitis—the necrotizing inflammatory process of the alveolar capillary going hand in glove with the necrotizing capillaritis, if you will, of the glomerular capillary tufts. The majority of their patients have presented hemoptysis. They showed varying degrees of glomerulonephritis, usually of an acute variety. In addition, three of the seven cases had periarteritis nodosa and most gave an allergic background.

I understand that the patient under discussion was a frequent visitor of an ear, nose, and throat man who was treating him for recurring allergic nasal polyps. The nasal congestion at the time of his admission possibly was also on an allergic basis.

Necrotizing alveolitis has been described with a variety of other conditions, principally sulfonamide hypersensitivity. It has been produced in animals by the injection of foreign proteins. It is rarely seen in the rheumatic syndrome. Dr. Sennett's diagnosis is perfectly correct. This man had a necrotizing angiitis with probable involvement of the nasal mucosa, possible involvement of the joints, and certainly involvement of the kidneys and pulmonary alveolar walls.

## MILWAUKEE ACADEMY OF MEDICINE SPONSORS ESSAY CONTESTS

Two essay contests are being sponsored by the Milwaukee Academy of Medicine again this year—the Horace Manchester Brown Memorial Prize Essay Contest and the Rogers Memorial Prize Essay Contest, the latter founded by the Rogers Memorial Sanitarium of Oconomowoc.

In the Horace Manchester Brown Memorial contest, the Academy offers prizes of $100 and $50 for the two best scientific essays in any field of medicine, surgery, or the allied specialties. The essays need not represent original investigation but should represent individual work and must not have been previously published.

The contest is open to all physicians who have graduated from medical school within the past ten years and are residing in the state of Wisconsin or are in the Armed Forces at the time the essay is submitted. Physicians who have been discharged from the Armed Forces and who have been graduated for more than ten years may submit essays if deduction of their period of service will bring them within the above-mentioned ten-year period after graduation. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays will be read at subsequent meetings.

Prizes of $200 and $100 will be offered in the Rogers Memorial Contest for the two most meritorious studies in the fields of neurology, psychiatry, and psychosomatic medicine. The contest is open to all members of the medical profession who are citizens of the state of Wisconsin, whether they are actually in residency or not, and to those who, though not ordinarily residents of the state, are stationed in Wisconsin in the Armed Forces. Awards will be determined by judges selected by the committee and will be presented at the annual meeting of the Academy of Medicine. Winning essays may be read at subsequent meetings and must be placed on file in the library of the Rogers Memorial Sanitarium, but may be submitted for publication (with proper acknowledgment) at the discretion of the author or the Rogers Memorial Sanitarium.

In both contests, all papers must be double spaced and submitted in triplicate to the office of the Milwaukee Academy of Medicine, 561 North Fifteenth Street, Milwaukee 3, Wisconsin, not later than December 1. The committee reserves the right to withhold the awarding of prizes if in its judgment no papers worthy of award have been submitted.

# Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

## Pain of Peptic Ulcer

Although a complete explanation of the pain of peptic ulcer cannot be presented at the present time, more and more information is becoming available which indicates a complexity of processes. The "Sippy treatment," for many years a classic and established procedure, is primarily a symptomatic treatment and does not necessarily supply any simple physiological basis for the interpretation of the phenomena, other than the relief of distress caused by gastric acidity in contact with the surfaces of peptic ulcers.

Palmer and Heinz[1] are likewise convinced that the pain of the peptic ulcer has as its origin the stimulus or irritation produced by acid; and the neutralization of this acid, as emphasized by Sippy, was basic to the relief effected by the so-called "Sippy treatment." They state, furthermore, ". . . . one must consider pain as the product of ulcer sensitivity, acid concentration and time." This concept involves a specific sensitivity, presumably due to an inflammatory condition induced by acid. These authorities furthermore state that there are two classes of patients; namely, "(1) those who had pain response to an acid stimulus but showed no pain in relation to gastric motility and (2) those who had no pain response to an acid stimulus but had pain during periods of gastric motility."

These statements indicate a complicated mechanism and cause Ruffin *et al.*[2] to remark that ". . . hydrochloric acid is the usual stimulus in the production of ulcer pain." However, they make the statement that ulcer pain is promptly relieved by a suitable nerve blocking agent, such as Banthine. Furthermore, they add that ". . . if motility is abolished by a suitable blocking agent, ulcer pain is promptly relieved even though acid barium can be demonstrated at the ulcer site."

Palmer and Heinz quote Gutzeit (p. 278) to the effect that there is no correlation between the size of the lesion and the severity of the pain. Winkelstein,[3] commenting on the report by Ruffin *et al.*, states: ". . . ulcer pain occurs in the absence of ulceration and also in the presence of healed ulcers."

Brummer[4] believes that the effects of bicarbonate of soda on relief of the distress of ulcers are due to effects on motility of the gut and not essentially due to the neutralization of acid. His formula for the control of gastric acidity is interesting, in that it involves a medicated toffee or tablet to be kept intact in the mouth until dissolved, without chewing, swallowing only as the material dissolves. It is made up of calcium silicate 0.25 Gm., magnesium oxide 0.12 Gm., magnesium carbonate 0.03 Gm., calcium carbonate 0.12 Gm., milk powder 1.0 Gm., sucrose 1.79 Gm. Neutralizing capacity of one tablet is 94 cc. of 0.1 normal HC1.

The foregoing remarks indicate nothing less than uncertainty, or at least a diversity of opinions as to how and why peptic ulcers behave as they do and what really is the immediate process giving rise to the sensation of pain. Most writers concur in the idea that the normal mucous membranes of the stomach and intestines can be burned, cut, or otherwise injured without the slightest evidence of any subjective sense of pain. One then wonders what can be the unique condition in peptic ulcers, or even in absence of ulcers, that gives rise to "ulcer pain." Muscle spasm is frequently referred to but is not generally emphasized as the possible or even likely cause of the pain. Probably everybody has had colicky abdominal pains, from babyhood through the green-apple age and on into the age of maturity. These pains are not likely to have been "ulcer pains" but rather smooth muscle spasms interfering temporarily with blood supply to the affected portion of the gastrointestinal tract, or stretching of the visceral peritoneal membrane. Conceivably, these spasms may be due to small groups of muscles, too limited in size to be sharply localized, and they may be recognized and relieved by physical measures as by the expulsion of gas. It is not beyond the

realm of possibility that all peptic ulcer pains have their origin in muscle as prodded into spastic activity by stimuli, such as the acid or other means of motor control of the gastrointestinal tract. One cannot overlook the remarkable fact that the normal gastric mucous membranes are entirely insensitive to physical trauma and yet are a definite factor in the control of the pylorus. It is not entirely illogical to surmise that under certain conditions the mucous membranes, inflamed or even apparently normal, may convey motor impulses to the muscular layers, which in turn manifest disturbances by spastic contractions of few or many smooth muscle fibers of the stomach or the duodenum which are interpreted by the patient as peptic ulcer pains.—A. L. TATUM, M. D.

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3. Winkelstein, A.: Mechanism of pain in peptic ulcer, Gastroenterology 23:266 (Feb.) 1953. (Discussion in symposium article by Ruffin).
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## PSYCHIATRY COURSE TO BE OFFERED BY ST. JOSEPH'S HOSPITAL, MILWAUKEE

The medical staff of St. Joseph's Hospital offers a course of ten weekly lectures entitled, "Emotional Problems Encountered in Everyday Medical Practice." Lectures will be given every Wednesday evening from 8 to 9:30 p.m., beginning on Wednesday, October 13, 1954, in the basement staff room of the hospital.

The course is designed for those physicians who see the earliest cases of emotional and behavior disorders, who must treat the majority of psychological problems in the community, and who are being called upon increasingly to preserve the mental health of the people. The objectives of the course are: 1. To introduce the doctor to broad patterns of human motivation and to the common causes and backgrounds of emotional disturbance; 2. To lead him to think in terms of the relation between emotional disturbance and illness; and 3. To teach easily understandable methods of therapy.

The course will consist of didactic lectures supplemented by slides and sound films. Each session will consist of a one-hour lecture followed by a thirty-minute question-and-answer period. There will be one session devoted to the demonstration of cases.

A distinguished faculty, with Dr. Chris Buscaglia as chairman, will discuss the following topics:

October 13—The Meaning and Diagnosis of a Psychoneurosis—Dr. John A. Stemper

October 20—Acute and Chronic Alcoholism and Addiction to Drugs—Dr. Paul J. Lawler

October 27—The Nature of Anxiety—Dr. Saul K. Pollack

November 3—Depressions—Dr. John A. Stemper

November 10—Psychosomatics—Dr. Samuel B. Black

November 17—Physician-Patient Relationships, Including Aspects of Long-Term Illness—Dr. Roland A. Jefferson

November 27—Demonstration of Cases to be Conducted at Milwaukee County Hospital for Mental Diseases—Dr. Michael Kasak

December 1—Panel Discussion—Dr. Francis J. Millen, Dr. Paul J. Lawler, Dr. Chris Buscaglia

December 8—Primitive vs. Contemporary Ways of Finding Happiness—Dr. William H. Studley

December 15—To be announced

The course is open to Wisconsin physicians. Credit for the American Academy of General Practitioners will be arranged.

The registration fee is $20. For further information, write Postgraduate Program, St. Joseph's Hospital, Milwaukee.

# School Health Services in Wisconsin Today

## As It Looks to Your State Board of Health

IN RECENT years increasing recognition has been given to the growing development of health programs for school age children. Better Health for Wisconsin School Children was set up as the aim of the Wisconsin Cooperative School Health Program started in 1940. Since then a desirable plan for each local school system in the related areas of healthful living, health services, and health instruction has been outlined under the state plan to help meet pupil health needs.

Effective functioning of the plan depends upon the understanding and the cooperation of many groups concerned with children and their health. The Wisconsin State School Health Council has 47 representatives from 36 organizations, including three members from the State Medical Society. It serves as a recommending and advisory group to the Wisconsin Cooperative School Health Plan and provides opportunity for coordinated effort at the state level. To encourage better local coordination, the 1952 Statewide Conference on Physicians and Schools has been followed by regional conferences in 1954, all sponsored by the State Medical Society in cooperation with the State School Health Council. These have been widely acclaimed as a constructive effort for better understanding of the problems involved in school health planning by physicians, dentists, school administrators, public health personnel, parents, and others.

The school health program of 1954 includes far more than the earlier efforts of inspection for communicable disease. Today the program is broad in scope; is based on scientific research; involves many more professional and lay persons; has many more teaching aids such as textbooks, bulletins, charts, posters, films, and film strips available; and has the advantage of more available community resources. Expansion of school health services in Wisconsin has been in keeping with the recommendations of the Joint Committee of the American Medical Association and the National Education Association. Their most recent report (1953) entitled "School Health Services" emphasizes the following: "School health services help to protect and improve the health of children, thus aiding their growth and development and enabling them to benefit fully from school experiences."

How well Wisconsin schools are carrying through on health services as a part of their total school health program has been brought out by a recent questionnaire sent to school administrators from the School Health Division of the State Medical Society and the State School Health Council. An analysis of the 403 surveys returned (83 per cent) disclosed the following practices and trends in Wisconsin:

The readiness-for-school examination is an established pattern in city school systems. Eighty-three of 114 replying have such a program. In 81 of the 83, the children are examined by the family physician in his office. This means thousands of children entering these schools are examined by their own doctors. Only 25 of 69 counties have similar programs.

Medical examinations of participants in competitive athletics are done in over 97.3 per cent of city school systems and in 94 per cent of the towns and villages.

One hundred seventy-two public school systems have a plan for medical examination of children in selected grades. In many schools there is examination of fourth, sixth or seventh, and tenth grade pupils as recommended, although the pattern differs widely as to the exact grades selected. Again the larger number are requesting these examinations to be done by the family physician in his office at the expense of the family.

Cities lead both towns and villages in that 38.5 per cent require health examination, including chest x-ray, of school employees, as compared to 29.3 per cent of all public school systems requiring examination. (Since 1947, the state statute 40.16 allows school boards to require health examination of school personnel and to budget monies for same.)

Vision screening is done annually in 337 elementary school systems replying (83 per cent), while the percentage of high schools is 55.1. The Snellen vision test is used in three-fourths of these school systems, and the predominant pattern is preliminary screening by the classroom teacher and then referral of the child to the family physician or eye doctor.

Over 90 per cent of the schools replying have periodic audiometric testing of school children.

Nearly 80 per cent of the school systems replying indicated they *do* distribute iodine tablets to school pupils.

Eighty-five per cent of the city superintendents and 95 per cent of the county superintendents replying indicated they have a program of immunization.

Tuberculosis case finding programs through tuberculin testing are under way in 49.4 per cent of

the school systems and chest x-ray for screening of high school pupils in 41.9 per cent.

Nearly 90 per cent of the elementary school systems responding keep cumulative health guidance records, with almost 85 per cent transferring them to high schools.

Certain conclusions are obvious. More school systems need to plan for periodic examination of pupils and school personnel; more emphasis on tuberculosis case finding seems indicated; vision and hearing screening programs need more emphasis at the high school level, as does distribution of iodine tablets to high school students. There needs to be a better extension of medical examination programs into rural areas—into both county and towns and villages. By continued coordination of interest and effort on the part of physicians and dentists, public health and school personnel, parents and children, the aim of Better Health for Wisconsin Children *can* be realized.—CATHERINE K. CAMPBELL, *School Health Consultant, Bureau of Maternal and Child Health.*

## EXHIBIT SPACE AVAILABLE AT WISCONSIN ACADEMY OF GENERAL PRACTICE ASSEMBLY

The Wisconsin Academy of General Practice has announced that it will accept requests from physicians and surgeons wishing to present scientific exhibits at the Academy's Sixth Annual Scientific Assembly, November 30 to December 1 at the Milwaukee Auditorium.

The Academy has reserved approximately ten booths for scientific displays and will furnish the booth, including tables, chairs, and electricity, free to a limited number of applicants. The booths are 10 feet by 10 feet. There will also be commercial exhibitors at the convention.

More than four hundred physicians are expected to attend the two full days of scientific talks, which feature speakers from Harvard and Chicago medical schools, the Mayo Clinic, and various other locations. Last year, three hundred physicians attended a two-day program at the smaller Hotel Schroeder.

Qualified physicians and surgeons interested in presenting scientific exhibits are requested to write for further information to Robert A. Dufour, Executive Secretary, Wisconsin Academy of General Practice, 758 North 27th Street, Milwaukee 8, Wisconsin.

## FELLOWSHIPS FOR BASIC RESEARCH IN ARTHRITIS

The Arthritis and Rheumatism Foundation is offering the following research fellowships in the basic sciences related to arthritis:

1. Predoctoral fellowships ranging from $1,500 to $3,000 per annum, depending on the family responsibilities of the fellow, tenable for 1 year with prospect of renewal.

2. Postdoctoral fellowships ranging from $4,000 to $6,000 per annum, depending on family responsibilities, tenable for 1 year with prospect of renewal.

3. Senior fellowships for more experienced investigators will carry an award of $6,000 to $7,500 per annum and are tenable for 5 years.

The deadline for applications is October 15, 1954. Applications will be reviewed and awards made in January 1955.

For information and application forms address the Medical Director, The Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, N. Y.

# . . . . THE PRESIDENT'S PAGE . . . .

FROM time to time one hears comments to the effect that prepaid medical insurance plans in this country were originated and fostered by organized medicine as a sort of desperate defense against *socialized* medicine. But I submit that this is not really an accurate representation of the situation. While the rapid and successful growth of insurance plans designed to ease the burden of medical expenses has undoubtedly done much to take the wind out of the socialized sails, nevertheless, I do not believe that we should regard this whole movement as a purely defensive one. Rather, I believe we should regard it as organized medicine's response to its obligations in the field of *social* medicine. And now, to satisfy the philosopher who said, "he who argues with me must first define his terms," let's take a brief look at *social* versus *socialized* medicine.

In the beginning, medicine's responsibility was to an individual with an individual illness. As knowledge regarding the causes and cures of disease increased, medicine's true and ultimate goal, the prevention of disease, slowly evolved. Concomitantly, came the science of sanitation and the science of immunology; and with these, medicine's responsibility began expanding beyond the individual and his individual disease to include many aspects of individual life in relation to community life. Thus were born our vast public health programs and departments, our community-wide immunizing programs, and our programs of health education. One of the basic principles that our health educators promote is that matters of health are so all-pervasive that they must be accepted by the individual as an individual responsibility towards himself, but more especially towards himself in relation to his fellow man. In fact, this is one of the fundamental tenets of our democratic, civilized culture—that the essential dignity and worth of the individual is recognized and respected by government as well as by other individuals. So, as a natural corollary to the doctrine of prevention, it was quite natural that efforts should be made to prevent some of the financial hardships which sometimes result from illness. Thus, utilizing sound insurance principles, plus the principle of individual responsibility, organized medicine is attempting to meet its obligation in the field of *social* medicine by promoting these various prepaid plans.

In the field of *socialized* medicine, the planners, of course, point to almost the same objectives, the prevention of disease and the prevention of financial hardship. But I believe that one of the basic faults in any *socialized* program is its tendency to minimize the individual's responsibility for himself. It is just*~~plans, both actuarially and administratively,~~ over, individual responsibility toward oneself is minimized and many of our individual prerogatives are put in jeopardy. In the medical field, the prerogative that would be jeopardized is the one most of us regard as basic, that of free choice of physician and free choice of patient. Any scheme of medical care that involves *compulsory* participation will sooner or later carry with it compulsory choice and thus severely damage our doctrine of free choice.

However, no insurance program can remain static and still fulfill its social responsibility. The enrollment of large industrial groups is nearing the saturation point. This not only retards the growth of the program but fails to include that large segment of our population not employed in groups, but just as vulnerable to the results of serious illness. Thus we are faced with the problem of working out plans, both actuarially and administratively, for covering small groups and even individuals. We are also faced with the problem of encouraging people to assume the responsibility of minor medical expenses, for which it may be possible to budget, while insuring themselves against the major medical expenses. In other words, there may be a place for the "deductible" type of contract; and there certainly is a place for our so-called "catastrophic" plan. By thus probing into new areas, we will be carrying on a lot of clinical research in the field of medical insurance; and at the same time we will be on the positive side in fulfilling our social responsibility, not on the negative or defensive side.

H. Kent Tenney M.D.

*plain inevitable that when government takes over,

Wisconsin Med. Jour. vol. 53 no. 10. Oct., 1954, p. 544.

*Facts about*

"THE DOCTORS' PLAN"

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

## A Hopeful Effort in Northwest Wisconsin

With the exception of bargain day at Macy's, it is a rare occasion when a salesman has the public "breaking down his door" in eagerness to buy his product. That is true even when the public needs his product and has a desire to purchase it. So it is axiomatic that a product must be *sold* in the most literal sense. Health insurance, it appears, is no exception.

This was the major theme in the launching of a new kind of selling program for Wisconsin Physicians Service in Northwest Wisconsin during August. Blue Shield wants to find out whether its product can be sold to the non-group potential by personal, direct, man-to-man selling, and whether this method offers the best immediate hope of enrolling large numbers of rural and small-town residents.

The new non-group enrollment program has been started in Polk County and will soon be expanded to Burnett, Barron, and St. Croix counties. Sales are being handled through a well-established local insurance agency with a number of part- or full-time representatives located in various towns throughout the four counties.

This is the first time in Wisconsin that a regular insurance agency has been engaged for the sale of Blue Shield and Blue Cross. It is the first time that a considerable number of sales representatives have been assigned to a relatively small area.

To test the validity of the theory that non-group enrollment is best obtained by personal contact selling, the agency will sell Blue Shield and Blue Cross only to individuals and families who cannot obtain group coverage. Persons who purchase the coverage will have the Blue Shield non-group contract which provides benefits for maternity, surgery, in-hospital medical care, anesthesia, and x-ray. Both the "A" and "B" schedule of benefits are offered. Special advertising and promotional efforts have been instituted to support the sales efforts of the agency.

The Commission on Prepaid Plans authorized the Northwest Wisconsin effort because it has been greatly impressed with the pleas of the self-employed and those who work in small businesses for Blue Shield and Blue Cross coverage like that protecting their neighbors who work in large plants. In Wisconsin this segment of the population constitutes a significant part of the whole.

At one time, neither plan had a contract for the self-employed (non-group) which provided the same benefits as group coverage. There has been gradual improvement, however; and, since last May, Blue Shield has been able to offer identical benefits to both group and non-group subscribers.

It is also important to note that now, for the first time, subscribers who work in businesses or organizations of less than five employees have the opportunity to pay their Blue Shield-Blue Cross premiums on a payroll deduction basis. Previously they could pay only quarterly, semiannually, or annually; and this procedure, in a sense, defeated the principle that Blue Shield and Blue Cross offer a method of budgeting health care costs.

These are important advances in making Blue Shield and Blue Cross available to the rural and small-town element of Wisconsin. Still more need to be made and will be undertaken as time and experience permit. The Northwest Wisconsin enrollment on a direct selling basis may point the way for greater improvements in the two "Blue Plans," which have always prided themselves on their social consciousness.

For Information or Advice:

Write • 704 E. GORHAM ST., MADISON, WIS. Phone • 6-3101 MADISON, WIS.

# THE WISCONSIN MEDICAL JOURNAL

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# « « « EDITORIAL » » »

## The Student Loan Fund

Conservatively speaking, contributions to the Student Loan Fund have been woefully inadequate. Lest anyone think there is not a continuing need for the Student Loan Fund, a recent article in the Journal of Medical Education on the cost of attending medical school for which 6,251 medical students from 26 selected medical schools were queried, showed that the average yearly cost, including tuition and expenses, was around $2,300. This figure was surprisingly close to that figure obtained by questionnaires sent to the administrative offices of the medical schools by the A. M. A. and reported in the 1952–1953 educational number of the *Journal of the American Medical Association.* Their average cost was $2,000 a year. In other words, excluding premedical years, a year of internship, and any more years taken in specialized training, four years in medical school will cost the student on an average of $8,000 to $9,000.

In considering the income of students, including all funds available to them, the study showed that 10 per cent reported unbalanced budgets, or 10 per cent of all students have to look to some type of student loan fund or loans from other sources to complete their medical training. Parents were the largest source of support for almost one-half of the students and were the only source of funds for 11 per cent of the students. At every school studied, one or more students expected to be in debt to the tune of more than $10,000; and these students totalled 3 per cent of the entire group.

The need for a Student Loan Fund is painfully apparent, and what other service investment is more deserving of our consideration?

## The AMA Headquarters Tour*

Next time you are in Chicago, plan to spend an hour touring the American Medical Association's building. You will find it to be one of the highlights of your trip to that great city. There is a regular tour service, and they are happy to escort one or several people through the building.

As a little test of public relations, your writer presented himself to the receptionist without prior

*Reprinted from the May 15 issue of the Bulletin of the Allegheny County Medical Society.

notice, and asked if he might be shown around. The reception was most cordial and within a few minutes, a young lady appeared to escort the party of one. We learned that the guides are especially trained in the tour service, as well as having other work in the building. Our escort worked in the publication department of "Today's Health," and donned her guide service badge as the occasion arose.

We started on the eighth floor of the large, modern office building. On the way up in the elevator, we learned that there were about nine hundred employees here and in the Washington office, and that eleven unions were represented among the employees. On the top floor, the work on the Quarterly Cumulative Medical Index goes forward. Also, the AMA has a package library service available to members, and this includes a large number of foreign journals. Here, too, manuscripts are processed for publication in the various journals printed by the AMA.

Since it is manifestly impossible in an article like this to give all the details of the tour, we shall try to concentrate on the highlights. For example, we saw the mail room that handles about thirty thousand pieces of incoming mail a month. The outgoing mail is in a separate area, as the volume is tremendously larger. "Today's Health" alone mails over a million pieces of literature a year. The building has its own postal inspector, and mail sacks are filled and handled in the basement. One of the sights is the huge stacks of empty mail bags sitting in the basement waiting to be used.

We visited the physics laboratory, where tests were being carried out on hearing aids, diathermy machines and respirators to see if they met the proper standards, and did what the manufacturer claimed for them. Nearby were the biochemical and chemistry laboratories, which carry out similar tests on new products and see that drugs match the required criteria. The results of the tests are mailed to the members of the several Councils, who then approve or disapprove the appliance or drug. Once approved, the manufacturer may print the seal of the Council on the package of his product. In these laboratories, too, a constant war is going on against adulteration of drugs and quack devices.

Another office of interest is that of the AMA Directory. Here records are kept of every physician from the time he enters medical school to the day of his death. Periodically these data are published in the Directory, but work is constantly going on to keep this updated. Our guide informed us that contrary to opinion, doctors move around a lot, and it is rather hard to keep up with some of them.

The AMA has a radio studio in the building for the purpose of making transcriptions that are sent out to radio stations all over the country. These may be a series of programs on health designed for the lay listener, or may be single programs. Another office of interest was that of the Council on Medical Economics, which has IBM cards representing most of the physicians in the country. From these, it is possible in a short time to determine how many female pediatricians aged 50–60 practice west of the Mississippi, or any other question dealing with the economics of medicine. Another department has a legal service available to members who are interested in creating or dissolving groups or partnerships, or other legal problems relating to practice. This service provides information, but does not actually do the legal work involved.

To an editor, the high point of the tour was in the basement where the JAMA is printed. All the specialty journals are printed in the AMA building, but "Today's Health" is printed elsewhere. We were fortunate the day we toured, for the week's run of the Journal was thundering through the huge four colored presses. The Journal is printed from Wednesday to Friday; then the plates are torn down, and it takes until the following Tuesday to set up the next week's issue. It is printed in sections of eight pages, then a machine automatically assembles the sections, a dash of glue is slapped across the binding, the cover is folded on, the complete magazine goes through a cutter to trim the edges, the address label is pasted on, and before you can say "adiadokokinesia" the Journals are pouring out in a constant stream to be stacked for mailing. It's worth the tour just to see this alone.

Here the tour ends, and the guide leaves you in the reception room with the feeling that our American Medical Association is doing fine work for all of us. Some day take the tour yourself. You will find that the AMA is not a cold, impersonal giant brooding over the medical world, but is composed of people like you and me who are trying to do a good job. By and large, we think they are succeeding.

## MEETING OF WISCONSIN SECTION OF INTERNATIONAL COLLEGE OF SURGEONS

The Wisconsin Section of the International College of Surgeons will have a dinner meeting at the Hotel Schroeder at 6 p.m. on October 3, 1954.

Requests for reservations should be addressed to: John T. Sprague, M. D., 109 East Johnson Street, Madison, Wisconsin.

# Annual Meeting

# Condensed Time Table

## SATURDAY, OCTOBER 2

7:00 p. m.: Interim Committee; Milwaukee Athletic Club

## SUNDAY, OCTOBER 3

12:30 p. m.: Council Meeting; Club Rooms, Hotel Schroeder

## MONDAY, OCTOBER 4

9:00 a. m.: First Session, House of Delegates; Ballroom, Hotel Schroeder
10:00 a. m.: Golf Tournament; Ozaukee Country Club
10:00 a. m.: Demonstrations; Milwaukee Auditorium
12:15 p. m.: Luncheons; Hotel Schroeder
2:00 p. m.: Reference Committees
2:30 p. m.: General Scientific Assembly; Milwaukee Auditorium
6:30 p. m.: Dinner and Awards; Ozaukee Country Club
7:30 p. m.: Entertainment and Buffet for Delegates and Exhibitors; Blatz Auditorium

## TUESDAY, OCTOBER 5

9:00 a. m.: Teaching Demonstrations; Exhibit Hall, Milwaukee Auditorium
9:00 a. m.: Reference Committees; Hotel Schroeder
10:00 a. m.: Scientific Sessions; Milwaukee Auditorium
(Pediatrics, Internal Medicine, Radiology, and Orthopedics)
12:15 p. m.: Luncheons; Hotel Schroeder
(Marquette Alumni Luncheon at Blatz Auditorium)
2:00 p. m.: Special Program on Anesthesia; Milwaukee Auditorium
2:00 p. m.: General Scientific Assembly; Milwaukee Auditorium
6:00 p. m.: Buffet Dinner, House of Delegates; Hotel Schroeder
7:30 p. m.: Second Session, House of Delegates; Ballroom, Hotel Schroeder

## WEDNESDAY, OCTOBER 6

8:30 a. m.: Third Session, House of Delegates; Ballroom, Hotel Schroeder
9:00 a. m.: Teaching Demonstrations; Exhibit Hall and Stage, Milwaukee Auditorium
10:00 a. m.: Scientific Programs; Milwaukee Auditorium
(Cardiac and Pulmonary Diseases, Obstetrics and Gynecology, Surgery)
12:15 p. m.: Luncheons; Hotel Schroeder
2:30 p. m.: General Scientific Assembly; Milwaukee Auditorium
5:30 p. m.: President's Reception; East Room, Hotel Schroeder
6:45 p. m.: Annual Dinner, Dance, and Floor Show; Ballroom, Hotel Schroeder

# Auxiliary Time Schedule

MONDAY, OCT. 4: 6:30 p. m.: Board of Directors; English Room, Hotel Schroeder
TUESDAY, OCT. 5: 9:00 a. m.: Business Meeting; Pere Marquette Room, Hotel Schroeder
1:00 p. m.: Luncheon; East Room, Hotel Schroeder
WEDNESDAY, OCT. 6: 9:00 a. m.: Business Meeting; East Room, Hotel Schroeder
1:00 p. m.: Luncheon and Style Show; Ballroom, Hotel Schroeder

[FOR COMPLETE PROGRAM SEE PAGES 505–536]

# THE MEDICAL FORUM

## DANE COUNTY SETS UP NEW EMERGENCY CALL SYSTEM

**The new emergency call plan of the Dane County Medical Society is a real public relations service. Physicians in other areas of Wisconsin will do well to establish similar systems in the larger centers of population.**

Madison, Aug. 16.—A new "emergency medical service" system has been established by the Dane County Medical Society to service the Madison area.

The new plan went into effect on September 1 with more than 100 Madison physicians cooperating.

**Dr. Otto V. Hibma, chairman of the emergency medical service committee, and committee members Dr. John T. Sprague and Adrian W. Davis developed the system.**

Now, when a person in the Madison area has no family physician or the family physician is unavailable during an emergency, he can call telephone number 5-8567. An operator at the Dane County Emergency Medical Service will in turn telephone the "physician-on-call" for that day.

### On Call 24 Hours

The physician will be given all information available about the emergency call, including the telephone number of the person calling, so the doctor can determine whether there is a true emergency.

**Physicians are on call for 24 hours, from 9 a.m. to 9 a.m. They are listed on a call schedule, one physician per day, and without regard to specialty. The Emergency Medical Service operator will call each doctor the morning that he goes on duty to remind him of his obligation.**

Any physician who cannot handle calls on the day assigned must obtain a replacement and notify the operator of the change.

Dr. Hibma said the new service replaces that formerly provided through the Nurses Registry which went out of business on August 31.

**In the past, Dr. Hibma said, the Nurses Registry received one or two emergency calls daily. Only**

*(Continued on page 499)*

## Rock County Plans Civil Defense Teams

Janesville, Aug. 1.—Rock county medical leaders were called together recently by Dr. Milton D. Davis, Janesville, to discuss the organization of several local mobile medical teams as part of the state civil defense program.

Drs. S. A. Freitag and E. W. Reinardy, both of Janesville, took part in the meeting. They are the captains of two local mobile medical units.

During the meeting Maj. Gen. Ralph J. Olson, state civil defense director, and Col. John W. Fitzpatrick, deputy director, discussed the organization of medical teams and the need for early action.

Dr. Carl N. Neupert, state health officer and director of health services for the State Office of Civil Defense, explained the role of the medical teams and their operating procedure.

Janesville is expected to develop 3 mobile medical teams, and Beloit is scheduled to set up another 3 teams.

DR. HIBMA

## AMA Offers New Exhibit About Sinus Trouble

Chicago, June 2.—Persons in your home town suffering from clogged heads and draining noses will be especially interested in the new exhibit, "Sinus Trouble," which the AMA Bureau of Exhibits is now offering to state and county medical societies for showings at fairs and other public gatherings.

## WARN YOUNGSTERS OF FAKE MAIL ORDER SCHOOLS IN MEDICAL TECHNOLOGY

Madison, Aug. 18.—More and more Wisconsin youngsters are being "taken for a ride" by correspondence schools which offer "diplomas" in medical technology.

**That's the opinion of officials of the University of Wisconsin Extension Division, the Wisconsin State Employment Service and the Madison Chamber of Commerce and Foundation as reported by George Rodgerson, staff writer for the *Wisconsin State Journal.***

The list of complaints is sad because they generally come from once ambitious youngsters who sought specialized knowledge through correspondence courses, only to become disillusioned when job opportunities failed to materialize at the completion of a course.

One of the frequent sources of complaints is from graduates of so-called medical technological schools. The employment office in Madison reports that several young people have enrolled in "medical technologist schools," with expensive tuitions, and found the certificates they hold are not accepted by nine out of 10 hospitals.

**The office points out that only those who follow a prescribed course of study, generally three years, and hold a certificate issued by the American Society of Clinical pathologists can get nationwide acceptance by hospitals and doctors.**

Youngsters who are interested in correspondence courses should never sign a contract immediately, but should consult a high school principal, a state employment office or similar guidance counselor.

# Blue Cross Issues 1953 Report; Paid $13,000,000 in Benefits

Madison, Aug. 15.—Wisconsin Blue Cross President B. E. Miller, administrator of Methodist Hospital, Madison, reports that over $13,343,000 was paid to hospitals during 1953 for care of subscribers and their families.

Miller reviewed the year's highlights in the 14th annual report of Blue Cross issued recently. During 1953 more than 56,000 persons joined Blue Cross, raising its total enrollment to nearly 935,000.

**Miller also reported that nearly 65,000 persons joined the two Blue Shield plans in Wisconsin, bringing their total enrollment to nearly 710,000. Blue Cross is the agent of Blue Shield for sales and billing purposes.**

Blue Cross reported that it had assets of about $5,300,000 as of December 31, 1953; liabilities of over $4,250,000 and reserves of about $1,100,000.

Hospital admissions of Blue Cross members totaled 152,600 during 1953 as against 135,000 the previous year.

**The report pointed out that hospital costs have been rising at a rate of about 12% each year, and "in spite of increased income, most of the non-profit hospitals are operating at a loss."**

Blue Cross reports that the average hospital charges per day for 1953 were $19.87, but in Milwaukee county average hospital costs per patient per day were about $23.00.

**Drs. J. C. Fox, La Crosse; R. F. Purtell, Milwaukee; J. S. Hirschboeck, Milwaukee; E. P. Hayes, Eau Claire; and C. D. Neidhold, Appleton, are members of the 21-man Blue Cross Board of Directors.**

## HISTORY SECTION MEETS OCTOBER 5

Madison, Sept. 1.—A special meeting of the Section on Medical History of the State Medical Society will be held during the Annual Meeting in Milwaukee.

Mr. Donald McNeil, assistant director of the State Historical Society, will present an interesting commentary on his efforts to collect evidence of the contributions of Wisconsin physicians to medical progress.

## Total of Physicians Highest Ever in 1953

Chicago, June 1.—The total number of physicians—218,522 licensed to practice in the United States set an all-time record in 1953. The official annual report on medical licensure showed that 7,276 new practitioners were added that year—an increase of 3,855 in the physician population, since 3,421 physicians died that year.

The present high level of medical education in this country is indicated by the fact that of the 5,646 graduates of approved medical schools, only 3.8 per cent failed to pass examination for licensure. Of the 1,463 graduates of foreign medical faculties examined, 45.5 per cent failed.

Of the 218,522 physicians, 156,333 were engaged in private practice, 6,677 were in full-time research and teaching, 29,161 were interns, residents, or engaged in hospital administration, 9,311 were retired, and 17,040 were in government service.

## Medical TV Show Starts in September

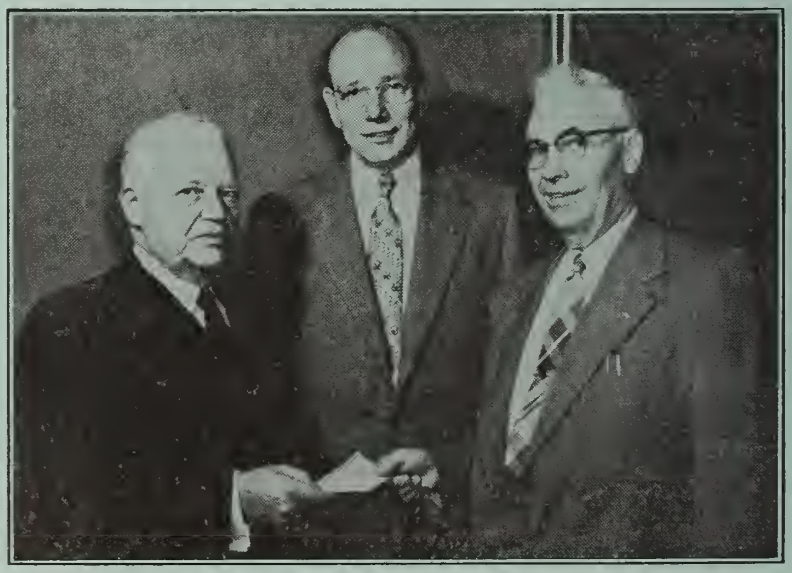
Madison, Aug. 19.—Starting in mid-September, medicine will play the hero role in a dramatic new national television program.

**The program, carrying the official endorsement of the Los Angeles County Medical Association, will be entitled MEDIC. The first program in the weekly series will be televised at 9 p.m., E.S.T., Monday, September 13, over the entire NBC network.**

This project was developed over the past two years by close cooperation between NBC and the medical profession in Los Angeles county.

Each case described in the MEDIC series tells the story of treatment of a patient by his doctor. Each script is approved by a medical committee, and a physician is present every time the program is televised.

Dow Chemical Company is sponsoring the series. NBC estimates that the first show will produce at least 20,000 letters from the public to state and county medical societies. The AMA urges that, because every letter carries public relations impact, each should be answered by the society receiving it.



**A CHECK FOR $7,500 from the sale of Easter Seals is presented to Dr. H. M. Coon, left, superintendent of the University Hospitals, Madison, by Clare D. Rejahl, right, president of the Wisconsin Association for the Disabled, and Kenneth L. Svee, executive secretary. The society contributes $15,000 a year to support the cerebral palsy center located in the orthopedic section of the hospital. Since its inception in 1952, about 400 children have received examinations and treatment.**

# ADVISE DOCTORS ON FEES FOR NEEDY PERSONS

**The following article on fees for those in difficult financial circumstances is a result of the thinking of 50 public-relations-minded practicing physicians of all parts of the United States. Their ideas on this subject have been collected by the American Medical Association, Department of Public Relations.**

No person needs to go without medical care in this country because he is unable to pay for it. Every day physicians provide care for persons who for good reasons are financially unable to meet their medical bills.

If people complain that medical care is unavailable to those without funds, it is because they are unaware that each year physicians quietly and modestly give millions of dollars worth of free medical care. Many medical societies have made public their willingness to provide medical care to anyone who cannot pay for it. These programs are meeting with good public relations effects.

### Two Philosophies

Like Hamlet, the physician often could deliver a soliloquy about the problem—"to reduce or not to reduce—or to cancel?" The hard task of deciding whether to reduce or cancel a fee entirely in a hardship case falls to the doctor.

There are two prevailing philosophies on this question. One belief is that a doctor should reduce his fee, but not cancel it, in order to save the patient's pride. The man who pays a small sum toward his expenses does not feel like a charity patient.

The second philosophy is that a doctor should never reduce—but completely cancel a fee if necessary. This evolves from the thought that a doctor should not bargain with his patients about charges.

### Ethics Govern

The inherent dangers in too readily reducing or cancelling medical fees are these: first, it encourages the irresponsible persons who feel the world owes them a living; second, it smooths the way for the cheats who dress up in shabby clothes when they come to the doctor to give the impression they are unable to pay for their medical care.

The Principles of Medical Ethics point out that "poverty of a patient . . . should command the gratuitous services of a physician." It is, however, especially difficult for a physician practicing in a large city to know whether or not the patient can pay for his care. Patients must be educated to discuss their financial problems with their doctor before contracting for care.

Here are some suggestions to guide a physician in deciding whether or not a fee should be reduced or cancelled:

1. Get adequate information about the patient's financial status.
2. Encourage advance fee discussions.
3. When a patient requests a lowered fee, investigate locally to learn whether the person is a bona fide needy case or a fake.
4. Determine whether or not needy persons are eligible under local and state public assistance programs. If so, put the patient in contact with these groups.
5. When referring patients to another MD, send financial information.
6. Make financial arrangements which best serve the interests of the patient.

The majority of patients are anxious to pay their own way. The physician often can settle the fee problem by following the directives of his heart.

## DESSLOCH ATTENDS BLUE SHIELD MEET

Madison, Sept. 12.—Dr. E. M. Dessloch, Prairie du Chien, attended a Chicago meeting of the Commission of the Blue Shield Medical Care Plans on Sept. 12.

Dr. Dessloch represents the Blue Shield plans of the 10th District on the Commission. This includes the states of Wisconsin, Minnesota, Iowa, Nebraska, North and South Dakota, and Montana.

The Blue Shield Commission reports that more than 30,000,000 persons are now enrolled in "the doctors' plans" throughout the nation.

## DANE COUNTY . . .

*(Continued from page 497)*

**about half of these were handled through the "emergency service" part of the Nurses Registry. The rest were answered by physicians who subscribed to the Nurses Registry as an answering service when they were not in their offices.**

Under the new set-up physicians who cooperate with the emergency medical service program will get a 24-hour tour of duty about once every three months. Currently about 110 physicians are signed up, and by January 1, 1955, Dr. Hibma hopes to add another 10 or more.


**TIME IS YOUR ONLY REAL ASSET**

You can fulfill all of your plans if you have time enough.

The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

The Time Insurance Company

213 WEST WISCONSIN AVENUE

Milwaukee 3, Wis.

*Disability Specialists since 1892.*

# MEDICAL NOTICE

DR. J. M. BALL

Has finally determined to live the rest of his life in Monroe.

IN BAR to the assertions that his charges are EXTORTIOUS, he hereby legally binds himself to conform to the annexed bill of prices, viz;

| | |
|---|---|
| For riding from 1 to 2 miles | $1.00 |
| For riding from 2 to 4 miles | 1.50 |
| For riding from 4 to 6 miles | 2.00 |
| For riding from 6 to 10 miles | 3.00 |

Visits in town, 50 cents each, or $1.00 a day in protracted cases.
Accouchements, from $3.00 to $5.00 per case.
Consultations, from $3.00 to $5.00 each.

In OPERATIVE SURGERY, charges will be in proportion to the nature of the case and complexity of the operation.

A word relative to the use of Calomel and the Lancet, as remedial agents in the treatment of disease. There are a few forms of diseased action in the successful treatment of which they are absolutely essential. But in the great majority of cases they SHOULD NOT be used.

P. S.—Dr. Ball has no SECRET NOSTRUMS to administer in the practice of his profession, but prefers, in every instance, to tell (to patient or friend) the medicinal qualities and properties of all his remedies, and their legitimate effect upon the system, in advance of their administration.

Office in Ludlow's block—upstairs—east of the bank.

**MEDICAL COSTS AND PUBLIC RELATIONS must have been a problem to physicians and their patients as long as a century ago. The above advertisement was reproduced from an issue of the Monroe *Sentinel* of May 23, 1855. This advertisement was brought to our attention by the Green County Historical Society.**

## BOARD OF HEALTH OFFERS PAMPHLETS

Madison, Aug. 20.—Three new pamphlets—dealing with fluoridation, tuberculosis and heart disease—are available through the State Board of Health.

Physicians interested in encouraging fluoridation of local water supplies will find a useful tool in the pamphlet entitled "Better Dental Health Through Fluoridation." It answers major questions about the process and shows the excellent results obtained in several Wisconsin communities.

A tuberculosis pamphlet urges all parents to have chest x-rays taken when the mobile unit visits the local neighborhood.

Hints on how to keep your heart healthy are given in the pamphlet on learning to "Live With Your Heart."

All are available in quantity upon request, and without cost.

## Deny Fluoridation Corrodes Pipes

Madison, Aug. 23.—Fluoridation of public water supplies has absolutely no relation to mineral deposits inside water pipes, according to O. J. Muegge, state sanitary engineer with the State Board of Health.

Controversies have developed recently in several Wisconsin cities where opponents of fluoridation have sought to blame this process for accumulations of sediment in local water supplies, discoloration of water, and deposits of minerals in water pipes.

Muegge reported to the State Medical Society that such conclusions "are absolutely without technical basis." He added, "We know of no chemist who could possibly agree that the addition of 1 p.p.m. of fluoride could create the chemical reactions alleged" by some individuals.

## State Serves as Test for Mass Evacuation

Madison, Aug. 17.—Wisconsin has been selected by the Federal Civil Defense Administration for a pilot study of the mass movement of people from metropolitan areas, according to Major General Ralph J. Olson, Madison, state director of civil defense.

Plans for moving people from Milwaukee and vicinity to out-state Wisconsin will be developed out of the study. The survey will be made by the Northwestern University Traffic Institute with a private firm of traffic consultants.

The survey is scheduled to be completed in September. It involves determination of escape routes from Milwaukee, studies of traffic loads, determination of how to direct people to the proper escape routes, and the impact of moving large numbers of people through and to outlying communities.

When the study is finished, state civil defense leaders and public officials will develop a state plan and the role of individual communities and counties in the plan.

## Lone Rock Reports "Tunnels" in Germany

Lone Rock, Aug. 19.— The Lone Rock Journal and the Richland Center Republican-Journal report an international interest in "uranium tunnels."

According to items in the two newspapers, a resident of Richland Center who is a native of Germany recently received the July issue of *Quick* magazine published in Germany. The magazine devotes a page to pictures and a write-up of a "uranium tunnel" located in Beckstein Baden, Germany.

The story relates that prospectors interested in gold found uranium in such quantities that the German Medical Society investigated the mineral as to its curative advantages.

"The association has built a five-story clinic, and hotel near the entrance of the underground tunnel. The guests are moved into the tunnel with electric train cars, where doctors and nurses are stationed to care for the ailing ones," the papers quote from *Quick*.

# PHYSICIANS ASKED TO HELP IN NURSING SURVEY

Wisconsin's physicians soon will be called upon through questionnaires, interviews, and participation in regional meetings to help determine how nursing education can best be geared to meet the acute shortage of qualified nursing personnel in Wisconsin.

**A "sampling" of physicians will be queried as part of a study now underway aimed at the "overall improvement of nursing care" in Wisconsin.**

Concerned that the shortage of nurses may "impede the recovery of the sick," a team of doctors, nurses, and educators will examine facilities for the training of graduate and practical nurses and recommend changes for better patient care.

The study was initiated by the Wisconsin State Board of Nursing and its Commission to Develop a State-Wide Plan for Nursing Education in Wisconsin. It is being conducted by the Institute of Research and Service in Nursing Education of Teachers College, Columbia University.

### Doctors Represented

Heading the Commission, which includes representatives of hospital, medical, nursing, educational, and lay groups, is Monsignor Edmund J. Goebel, superintendent of schools of the Archdiocese of Milwaukee.

**The medical profession is represented by Dr. A. H. Heidner of West Bend and Dr. Burton A. Waisbren of Milwaukee.**

The questionnaire for doctors will try to get at duties which office nurses are expected to perform, use of visiting nurses, success in securing nurses for patients requiring home care, desirable qualities in nurses, skills which are expected of nurses with differing levels of training, the quality of nursing care in hospitals, and the kinds of nursing service most urgently needed.

### Five Steps in Survey

According to Helen Bunge, director of the study and executive officer of the Institute of Research and Service in Nursing Education, the following steps will be taken to collect information and identify problems in nursing education.

**1. Analysis of institutions where instruction and practice for nursing may be obtained and the kind of instruction available.**

**2. Review of records from schools of nursing and the Wisconsin State Department of Nurses.**

**3. Distribution of questionnaires to physicians, hospitals, practicing nurses, and public health agencies.**

**4. Visits by an expert survey team to schools of nursing, hospitals, and other nursing service agencies.**

**5. Interviews by members of the survey team with patients, physicians, hospital administrators, educators, and lay groups concerned with developing nursing education programs which will better meet the needs of patients.**

Medical member of the survey team is Dr. Jean Curran, Associate Executive Dean for Medical Education, State University of New York.

At the conclusion of the study, reports and suggestions for improvement will be made to appropriate state groups, and recommendations will be made for future developments in nursing education to meet changing needs in the state.

DR. HEIDNER

DR. WAISBREN

"Emphasis will be placed on problems in the education of nurses that arise out of the needs in the care of patients," says Miss Bunge, noting that "future experimentation in nursing education to improve nursing care might be needed."

## Doctors Invited to Blue Shield Lounge

Madison, Sept. 1.—All physicians are urged to visit the Blue Shield of Wisconsin lounge at the State Medical Society Annual Meeting in Milwaukee, Oct. 4–6.

The Blue Shield booth will provide a rest area for physicians attending the scientific sessions in the auditorium. The lounge will be located at the north end of the exhibit hall.

In addition to getting information about Blue Shield which will be available from several representatives of the plan at all times, physicians will be able to relax over a cup of coffee or a "coke."

PROFESSIONAL BUSINESS SERVICE
221 State Bank Building
La Crosse, Wisconsin
Our helpful brochure
"How to Make Your Practice More Successful"
available on request.

# WISCONSIN PHYSICIANS ARE LEADERS IN AMA

Wisconsin leadership is being felt throughout the American Medical Association.

At least seven physicians who have their roots in Wisconsin are currently serving the AMA in high official capacities. Yet few Wisconsinites are aware of their contributions to medical progress and organization.

Perhaps the "ranking" Wisconsin physician in AMA circles is **Gunnar Gundersen, M.D., of La Crosse.** He is a member of the Board of Trustees, chairman of its executive committee, chairman of the Department of Public Relations, and a member of the Council of the World Medical Association.

Dr. Gundersen, a surgeon, was president of the State Medical Society in 1942, a former member of the Board of Regents of the University of Wisconsin, and the chairman of the Joint Commission on Accreditation of Hospitals during its formative years.

**DR. GUNDERSEN**
**Board of Trustees**

**DR. SARGENT**
**National Defense**

### Three Milwaukeeans

Another former president of the State Medical Society, **Dr. James C. Sargent, Milwaukee,** holds high office as chairman of the AMA's Council on National Defense. A urologist, Dr. Sargent had a distinguished career in the naval service during World War II and since then has been a crusader for improved medical service in the Armed Forces and better civil defense planning for the nation.

As chairman of the Council on National Defense he works closely with the Armed Forces in formulating plans for providing health personnel in times of emergency. The Council helps to integrate the medical profession in civil defense planning and prepares training courses for specialized disaster personnel.

**O. A. Sander, M.D., Milwaukee,** is a member of the AMA's Council on Industrial Health. He is well known for his efforts in the prevention of silicosis and tuberculosis among industrial workers.

A full-time specialist in industrial medicine, Dr. Sander contributes much to the work of the Council on Industrial Health.

The Council's chief objective is to convince both labor and management that preventive medicine is equally as important as curative medicine in industry. The Council issues reports on such subjects as noise in industry, environmental hygiene, safety, health education, workmen's compensation. It also sponsors an annual Congress on Industrial Health.

Another Milwaukeean serves the AMA as chairman of its Committee on Cosmetics. **Harry R. Foerster, M.D.,** is a dermatologist and works through his AMA committee to disseminate information to the profession and the public concerning the usefulness, limitations and health problems of cosmetic preparations.

The Committee evaluates cosmetics submitted to it, and those found acceptable are permitted to use the Committee seal of acceptance.

A noted Wisconsin biochemist, **C. A. Elvehjem, Ph.D., Madison,** is a member of the AMA's Council on Foods and Nutrition.

Dr. Elvehjem is dean of the graduate school at the University of Wisconsin. The AMA Council with which he is affiliated evaluates nutritional claims for special purpose foods such as infant formula products, protein supplements, and those used in low-calorie and low-sodium diets. It also appraises general purpose foods with wide public health significance such as Vitamin–D fortified milk, fruit juices and iodized salt.

The Council has been particularly successful in improving foods and their advertising and in educating the public about the importance of nutrition.

Many others from Wisconsin now lend their arts and talents to the American Medical Association. **W. W. Bauer, M.D.,** director of the Bureau of Health Education, Editor of "Today's Health," and noted physician–educator and author,

**DR. SANDER**
**Industrial Health**

**DR. FOERSTER**
**Cosmetics**

was graduated from the University of Wisconsin and served for several years as city health officer in Racine.

**Robert T. Stormont, M. D.,** secretary of the Council on Pharmacy and Chemistry of the AMA, is a native of La Crosse.

**Frederick T. Jung, M.D.,** director of the AMA's Physical Laboratory, is a graduate of the University of Wisconsin.

**Walter Wolman, Ph.D.,** is a native of Milwaukee. He is director of the Chemical Laboratory at AMA headquarters.

**George B. Larson,** assistant director of the Bureau of Exhibits in the AMA, was formerly on the staff of the State Medical Society of Wisconsin in Madison.

The latest Wisconsin addition to the staff of the American Medical Association is Frank Kuehl, formerly of Madison. Until recently he was affiliated with the Reconstruction Finance Corporation. He now serves the AMA as legal advisor in its Washington, D. C., office.

These are Wisconsin's contribution to the operations of the American Medical Association. They stand out among the hundreds of council and committee members who guide the policies of the AMA and the 900 staff employees who carry out its activities.

## "Operation Herbert" Film Available for Local Showings on Sept. 1

Once a hit, always a hit, can certainly be repeated about the motion picture film — "Operation Herbert"—which already has been a television success throughout the country during the past year. After Sept. 1, this amusing 16 mm. film on the cost of medical care will be available for showings at clubs, schools, health classes, fairs, farm and church groups and other organizations in your community.

Produced by the AMA, this 30-minute film stars Jackie Kelk as the young hospital patient who demonstrates to his penny-pinching Aunt Agatha and attractive nurse that an appendectomy costs less today than in 1937.

Bookings may be made through the State Medical Society office, 704 E. Gorham St., Madison.

## SOCIETY OFFERS "HEALTH TAPES" TO STATE HIGH SCHOOL TEACHERS

Madison, Aug. 26.—Wisconsin high school teachers again have the opportunity to use a series of State Medical Society tape recordings for health education.

The recordings, presented originally as 15-minute programs on the "March of Medicine" radio series under the direction of Dr. Robert C. Parkin, Madison, are useful in teaching biology, physiology, hygiene, home economics, health education and physical education.

**This is the second school year during which the programs have been offered by the Society. During the 1953–54 school term, nearly 100 high schools ordered the tape recordings for teaching purposes.**

The "Health Tape" series has been received with enthusiasm by all who have used it. Among the subjects available on the tapes are discussions of acne, heart disease, vitamins, cancer, overweight, colds, sleep, psychosomatic illness, the digestive system, and medical facts and fallacies.

Study guides are sent with each tape recording so that the teacher may review the script of the tape recording and be prepared to explain medical terminology, prepare demonstrations and the like.

**The service originated with the Society's Council on Medical Service and won nation-wide attention at the American Medical Association's public relations conference as an example of "health education at its best."**

## TIME TO SEE YOUR CONGRESSMAN

**With the end of the 1954 session of Congress, most Congressmen will be back home and available for discussions with constituents.**

**All Wisconsin Congressmen have issued invitations to their constituents for discussions of federal legislation, advice or merely "for a friendly visit."**

**Physicians, like other citizens, should take this opportunity to discuss matters of interest to themselves and the medical profession before Congressmen are called back into session.**

## MD's Address Polk County Conference on Mental Health

Madison, Sept. 3.—Dr. Leslie A. Osborn, professor of psychiatry at the University of Wisconsin Medical School, and director of mental hygiene for the Wisconsin Department of Public Welfare, was headline speaker at the Polk County Mental Health Conference held at the Amery high school June 1 and 2.

Theme of the conference was "How Schools Can Help Children with Emotional Problems." Cosponsors of the event were the Polk County Medical Society, Polk County Health Council and the State Division of Mental Hygiene.

Other leaders in the mental health field who took part in the program were Rudolph Mathias, psychologist for the diagnostic center and instructor in clinical psychology, University of Wisconsin; Dr. Robert E. O'Connor, University of Wisconsin and Division of Mental Hygiene; and Mrs. Leslie A. Osborn.

## New Radio Series Gives Health Tips to Age 35

Chicago, June 1.—How to lead a healthy, happy life when you reach the halfway mark—35 years of age—is the theme of a new radio transcription series prepared by the AMA's Bureau of Health Education.

Based on an article by Dr. Donald A. Dukelow of the bureau's staff which appears in the July issue of "Today's Health," this series stresses the fact that "Thirty-five is the halfway point — the time to check for defects before adding more mileage and more wear and tear to vital organs."

The following subjects are included: heart disease, cancer, arthritis, high blood pressure, mental health, surgical advances, rehabilitation, preparation for old age, endocrinology, diseases of the blood, general therapeutics, nutrition and diabetes.

The series became available in July for distribution to state and county medical societies for airing over local radio stations.

# Physicians Should Schedule Appointments To Cause Patients a Minimum of Waiting

Mrs. Leslie hired a baby sitter at a good price so she could come to the doctor. She was kept waiting two hours. John Brinks, vice-president of a local company, missed an important committee meeting because he had to wait to see the doctor.

The doctor was not entirely to blame. He had been called away on an emergency and his secretary had scheduled his appointments too closely. An appointment with the doctor is important to the patient—if he has to wait a long time, he becomes irritated and resentful. A recent survey showed patients complain twice as much about long waiting as about fees.

### Scheduling Helps

**Even though emergencies make it difficult to eliminate all waiting, most physicians can cut unnecessarily long waits by practicing efficient scheduling of appointments. A waiting room costs money in terms of rent, furnishings and upkeep. Today the trend is toward a smaller reception room because more doctors are seeing patients on an appointment basis.**

A professional management official reports that a physician who switched to the appointment system saw one-third more patients in a month's time than previously, but was not aware of it because he didn't "feel pushed."

### Encourage Office Calls

Patients without appointments should be worked into the schedule if possible, but the doctor or his assistant should say something like this: "The doctor will be able to see you this time, but would appreciate your making an appointment the next time you come in." Patients soon learn appointments save their time, too.

**Home calls should also be scheduled efficiently. Physicians should urge patients to come to their offices for treatment when possible, pointing out that the facilities for the best medical treatment are available there and that office calls are more economical.**

In one doctor's office, his assistant routes home calls on a large city map, thus saving the doctor time often lost in aimless searching for streets and houses, and in backtracking.

Efficient scheduling of appointments reduces strain on the doctor and increases his ability to give his patients the best medical service. Here are scheduling suggestions offered by MDs:

1. **Arrange office hours to fit community needs. Some doctors hold evening office hours two or three times a week for the convenience of working patients.**
2. Schedule all appointments using tact, patience and finesse and conveying the impression that you are trying to arrange a time when you can give the patient your complete attention.
3. Use an appointment book marked off in given time intervals. On the basis of your experience, allot given times for first visits, check-ups and other procedures. Adjust your schedule to fit your practice.
4. **Don't make conflicting engagements.**
5. Don't overcrowd the schedule. Allow two or three vacancies during the day for catching up or as "breathers."
6. Schedule house calls realistically, at hours not conflicting with office hours.
7. **Fit referred patients and patients without appointments into your schedule as best you can. Some MD's leave late afternoon and early evening appointments open for patients needing immediate action.**
8. If it is necessary to refuse an appointment, always explain why.
9. When an emergency takes the doctor out of the office, the situation should be explained to waiting patients; give them the choice of waiting or of making a new appointment.
10. **If it is necessary to cancel an appointment, notify the patient and make a new appointment.**
11. Always give patients a written or oral reminder of their appointment.

If patients are kept waiting long, they are due an explanation. The doctor or his assistant should make it clear they are keenly concerned about the delay. When the doctor is unexpectedly called out of his office, his receptionist should say something like this:

"Dr. Black has been called out of the office on an emergency. It may be an hour or so before he returns. He is very sorry to inconvenience you and asked me to inquire whether you want to wait or would like a new appointment." Or: "Perhaps you would like to shop and come back in an hour. I feel sure the doctor will be able to see you then."

Patients' time is valuable too!

(*Note:* This article was reprinted from the new AMA Public Relations Manual.)

## SPECIAL OFFER ON "TODAY'S HEALTH"

Madison, Aug. 27.—The editors of "Today's Health" are making a special introductory offer of 6 issues for one dollar as a means of making physicians and others aware of the nation's foremost health magazine.

The one dollar offer is less than half the cost of the six issues when purchased on newsstands. Physicians interested in the offer are urged to write to:

**Today's Health**
American Medical Association
535 N. Dearborn St.
Chicago 10, Illinois.

The offer is limited, so orders must be sent immediately. Be sure to mention the special introductory offer.

Physicians will do well to have at least one copy in their reception rooms at all times. "Today's Health" makes a fine gift for Christmas, birthdays and other special occasions, and a valuable contribution to local schools and places of employment.

## Fatal Accidents High On Cause-of-Death List

Madison, May 6.—Fatal accidents account for more deaths in the U. S. than any other cause except cardiovascular diseases and cancer, according to statistics compiled by the Metropolitan Life Insurance Company. This was true during 1953 for all states of the Union except New Mexico, where accidents passed up cancer as well.

# 1954 Annual Meeting

## MILWAUKEE — OCTOBER 4-5-6

## Special Features . . .

**GOLF:** MONDAY, OCT. 4: Ozaukee Country Club. Tee off at 10:00 a. m. Reservations through A. H. Luthmers, Room 700, 208 East Wisconsin Avenue, Milwaukee 2. $9.00 per person, including dinner, green fees, prizes, and entertainment.

**TEACHING DEMONSTRATIONS:**
MONDAY, OCT. 4: 10:00–11:00 a. m., 3:00–3:45 p. m.
TUESDAY, OCT. 5: 9:00–10:00 a. m., 3:00–3:45 p. m.
WEDNESDAY, OCT. 6: 9:00–10:00 a. m.

1. Postanesthesia Recovery Room: Wisconsin Society of Anesthesiologists; James W. Bookhamer, M. D., Milwaukee, and associates.
2. Meeting the Needs of the Amputee: Ray Piaskoski, M. D., and associates, VA Medical Center, Wood
3. The Cranial Cavity (Dissections): Anatomy Dept., University of Wisconsin Medical School, F. D. Geist, M. D., and P. H. Settlage, M. D.
4. OB Manikin Demonstrations: (Through Wisconsin Society of Obstetrics and Gynecology)
5. Gross Tissue: Display and discussion by members of the Wisconsin Society of Pathologists.
6. Fracture Demonstrations: By members of Wisconsin Orthopedic Society, under direction of Joseph Stone, M. D., Milwaukee

**DINNER . . . With Floor Show and Dancing:** This will be the final event of the Annual Meeting, on Wednesday, October 6. Following a short "serious program" and the granting of awards to new members of the "50 Year Club," the program will consist of professional entertainment, followed by a dance, until midnight.

**FAMOUS SPEAKERS:** A review of the following pages will show the high quality of the program provided. Speakers from all parts of the country will be featured on the various programs listed.

**FUN!** Ample provision is made for meeting with old friends. Special luncheons and dinners will provide an opportunity for relaxation and renewal of acquaintances. Be sure to plan to attend! Arrange your schedule so you can be in Milwaukee on October 4–5–6!

# COUNCIL ON SCIENTIFIC WORK

*Members in Charge of Planning 1954 Annual Meeting Program*

J. W. GALE
Chairman

P. A. MIDELFART
General Program Chairman

S. A. MORTON
Director, 1955 Postgraduate Teaching Programs

M. G. RICE
Chairman, Scientific Exhibits

L. G. KINDSCHI
Chairman, Teaching Demonstrations

R. S. BALDWIN
Medical Editor, Wisconsin Medical Journal

J. S. HIRSCHBOECK
Dean, Marquette University School of Medicine

W. S. MIDDLETON
Dean, University of Wisconsin Medical School

# OFFICERS

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Madison
President

F. L. WESTON
Madison
Treasurer

L. O. SIMENSTAD
Osceola
Speaker

J. C. GRIFFITH
Milwaukee
Past President

A. J. McCAREY
Green Bay
President-Elect

J. W. FONS
Milwaukee
Vice-Speaker

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Frederic
Chairman of Council
Councilor, 10th District

S. E. GAVIN
Fond du Lac
Chairman Emeritus

W. H. COSTELLO
Beaver Dam
Councilor, 1st District

T. C. HEMMINGSEN
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Councilor, 2nd District

N. A. HILL
Madison
Councilor, 3rd District

H. E. KASTEN
Beloit
Councilor, 3rd District

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Councilor, 4th District

A. H. HEIDNER
West Bend
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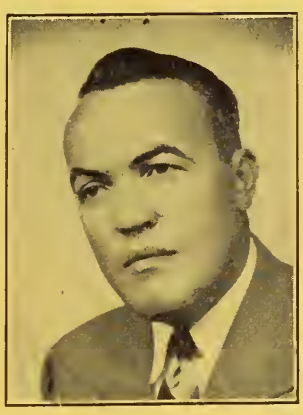
Councilor, 6th District

# COUNCILORS FOR 1954

J. C. FOX
La Crosse
Councilor, 7th District



J. M. BELL
Marinette
Councilor, 8th District

R. E. GARRISON
Wisconsin Rapids
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V. E. EKBLAD
Superior
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N. J. WEGMANN
Milwaukee
Councilor, 12th District

W. T. CASPER
Milwaukee
Councilor, 12th District

C. E. ZELLMER
Antigo
Councilor, 13th District

# TEACHING DEMONSTRATIONS

## *Special Daily Programs Offered for Direct Teaching to Small Groups*

Each day during the 1954 Annual Meeting there will be a series of teaching programs offered at the times indicated below. These programs are designed to present special problems in various fields which will be of special concern to the general practitioner. The Council on Scientific Work has had the special assistance of L. G. Kindschi, M. D., Monroe, in the development of these programs,with the cooperation of the special medical groups or departments conducting the teaching demonstrations.

This is an important part of the scientific program, and your active participation in the lectures and discussions is requested. All programs will be held in the main exhibit hall at the hours indicated.

### Demonstration Schedule

**Monday, October 4: 10:00–11:00 a.m. and 3:00–3:45 p.m.**

**Tuesday, October 5: 9:00–10:00 a.m. and 3:00–3:45 p.m.**

**Wednesday, October 6: 9:00–10:00 a.m.**

**S–57, 58, 59 MEETING THE NEEDS OF THE AMPUTEE**

**Ray Piaskoski, M.D., and Associates, VA Hospital, Wood**

This will be a demonstration of the modern teamwork concept of rehabilitation designed to meet the needs of the amputee. Rehabilitation of a severely disabled patient requires the coordinated effort of many individuals, including doctors, nurses, rehabilitation therapists and technicians, vocational counselors, social workers, the patient, his family, and friends. This demonstration emphasizes particularly the role of the physician, the physical therapist, the limb maker, and the vocational counselor. Patients will be used for demonstration purposes.

**S–55, 56 OB MANIKIN DEMONSTRATIONS ON SPECIAL PROBLEMS OF DELIVERY**

**Members of the Wisconsin Society of Obstetrics and Gynecology**

Each day teaching demonstrations on the subjects listed will be held, with the use of a manikin. Full opportunities for discussion and questions will be provided:

**Monday, October 4:**

**10:00–11:00 a.m.: Version Extraction and External Version:** L. T. Servis, M.D., Milwaukee

**3:00– 3:45 p.m.: Management of Transverse Presentation and Breech Presentation:** Elizabeth A. Steffen, M.D., Racine

**Tuesday, October 5:**

**9:00–10:00 a.m.: Version Extraction and External Version:** David J. Werner, M.D., Milwaukee

**3:00– 3:45 p.m.: Management of Transverse Presentation and Breech Presentation:** S. D. Austin, M.D., Green Bay

**Wednesday, October 6:**

**9:00–10:00 a.m.: Manual and Forceps Rotation of the Occiput Transverse and Occiput Posterior Presentations and Positions:** Russell Lewis, M.D., Marshfield

**S–53, 54 THE CRANIAL CAVITY**

**Frederick D. Geist, M.D., and Paul H. Settlage, M.D., Department of Anatomy, University of Wisconsin Medical School**

The daily demonstrations will be on certain aspects of the cranial cavity which are of special interest and concern to the general practitioner, not only as anatomical demonstrations, but as demonstrations directly related to clinical problems that are a consequence of disease or of injury. In one specimen the cranial meninges, cerebral veins, fluid spaces, meningeal vessels, and dural sinuses will be featured. The second specimen will present the dorsal view of the brain stem, and a complete laminectomy will show the roots of the cranial nerves and their relationships to other structures, the spinal nerve roots, and cauda equina.

**S–35, 36 THE POSTANESTHESIA RECOVERY ROOM**

**Wisconsin Society of Anesthesiologists**

This demonstration will be an exhibit of the equipment used in a postanesthesia recovery room and a demonstration and discussion of such equipment. Pictures of recovery rooms in various hospitals will be shown. The demonstrations will be under the general direction of J. W. Bookhamer, M. D., Milwaukee, and other members of the Wisconsin Society of Anesthesiologists.

**S–33, 34 ORTHOPEDIC DEMONSTRATIONS**

**Wisconsin Orthopedic Society**

A variety of demonstrations of special orthopedic problems of interest to the general practitioner will be presented. Included will be the treatment of fractures of the shaft of the humerus by hanging cast method, fractures of the ankle, and intramedullary nailing of the femur. The demonstrations are under the general direction of Joseph R. Stone, M. D., Milwaukee; and medical students will be used for demonstration purposes.

*No afternoon demonstrations will be conducted.*

**S–28, 29 GROSS TISSUE DEMONSTRATIONS**

**Wisconsin Society of Pathologists**

The demonstration consists of currently available gross specimens, fixed and fresh, of special or general interest. They are drawn from surgical and autopsy cases. Wisconsin pathologists will discuss the material presented. The demonstrations are under the general direction of Gorton Ritchie, M. D.. Milwaukee.

# PROGRAM FEATURES

# MONDAY OCTOBER 4

## *House of Delegates:* HOTEL SCHROEDER

The opening session of the House of Delegates will be held in the Ballroom, Fifth Floor, Hotel Schroeder, at 9:00 a. m., Monday, October 4. All delegates should be registered prior to the opening of the House. Registration will be in the Fifth Floor foyer of the Hotel Schroeder, and credentials can be checked at that time.

## *Scientific Programs:* MILWAUKEE AUDITORIUM

### 10:00–11:00 a. m.: DEMONSTRATIONS

**Space S–28–29: GROSS TISSUE: Wisconsin Society of Pathologists**

The demonstration consists of gross specimens, fixed and fresh, currently available and of special or general interest. They are drawn from surgical and autopsy cases.

**Space S–33–34: FRACTURE DEMONSTRATIONS: Wisconsin Orthopedic Society**

Special attention will be directed to handling of fractures of the shaft of the humerus by hanging cast method and also fractures of the ankle. Intramedullary nailing of the femur will also be discussed.

**Space S–35–36: THE POSTANESTHESIA RECOVERY ROOM: Wisconsin Society of Anesthesiologists**

This demonstration will be an exhibit of the equipment used in a postanesthesia recovery room and a demonstration and discussion of such equipment. Pictures of recovery rooms in various hospitals will be shown.

**Space S–53–54: THE CRANIAL CAVITY: Department of Anatomy, University of Wisconsin Medical School**

One specimen will show the cranial meninges, cerebral veins, fluid spaces, meningeal vessels, and dural sinuses. A second specimen will present a dorsal view of the brain stem and a complete laminectomy to show the roots of the cranial nerves and their relationships to other structures. The demonstrations are planned primarily for general practitioners confronted with cases of common head injuries.

**Space S–55–56: OB MANIKIN DEMONSTRATIONS: Wisconsin Society of Obstetrics and Gynecology**

Morning Demonstration: "Version Extraction and External Version": L. T. Servis, M. D., Milwaukee

Afternoon Demonstration: "Management of Transverse Presentation and Breech Presentation": Elizabeth A. Steffen, M. D., Racine

**Space S–57–59: MEETING THE NEEDS OF THE AMPUTEE: Ray Piaskoski, M. D., and Associates, VA Medical Center, Wood**

The demonstration will emphasize the teamwork concept of rehabilitation, including the part played by the physician, nurse, physical therapist, limb maker, and vocational counselor. Patients with amputations will be used for demonstrations.

# Monday Oct. 4

JOHN ADRIANI, M. D.
New Orleans

LEO H. BARTEMEIER, M. D.
Detroit

PAUL C. WILLIAMS, M. D.
Dallas, Texas

**12:15 p. m.: LUNCHEONS** (See opposite page for listings)

**2:30 p. m.: GENERAL SCIENTIFIC ASSEMBLY**

JUNEAU HALL MILWAUKEE AUDITORIUM

MODERATOR: P. A. Midelfart, M. D., Eau Claire General Program Chairman for the 1954 Annual Meeting.

**2:30 p. m.: WHAT PATIENTS EXPECT OF THEIR PHYSICIANS**

*(Theresa Rogers Memorial Lecture, Rogers Memorial Sanitarium)*

Leo H. Bartemeier, M. D., Associate Professor of Psychiatry, Wayne University, Detroit

**3:00 p. m.: SURGICAL RISKS FROM THE STANDPOINT OF ANESTHESIA**

John Adriani, M. D., Professor of Surgery, Tulane University School of Medicine, New Orleans

**3:30 p. m.: RECESS TO VIEW EXHIBITS AND DEMONSTRATIONS**

DEMONSTRATIONS:

**Gross Tissue:** Wisconsin Society of Pathologists

**The Cranial Cavity:** University of Wisconsin Department of Anatomy

**Meeting the Needs of the Amputee:** VA Medical Center, Wood

**OB Manikin Demonstration: "Management of Transverse Presentation and Breech Presentation":** Elizabeth A. Steffen, M. D., Racine

**The Postanesthesia Recovery Room:** Wisconsin Society of Anesthesiologists

SCIENTIFIC EXHIBITS:

(See pages 524–526 for complete listing of scientific exhibits)

**4:15 p. m.: LOW BACK PAIN**

Paul C. Williams, M. D., Clinical Associate Professor of Orthopedic Surgery, Southwestern Medical School of the University of Texas, Dallas

# ROUND TABLE LUNCHEONS

## *Monday, October 4*

*Note:* All luncheons listed will be held at the Hotel Schroeder from 12:15 until 2:00 p. m. Attendance is limited, so if you have not made your reservations, do so immediately. List three choices in order of preference. (At the time of publication, the luncheon of Dean Middleton is completely filled.) Cost: $2.50 per luncheon. Make your check payable to the State Medical Society of Wisconsin.
If any reservations remain, tickets can be secured in the fifth floor foyer of the Hotel Schroeder at 12:00 noon on the day of the luncheon.

1. LEO H. BARTEMEIER, M. D., Detroit: "Everyday Emotional Problems in Medical Practice"
   Chairman: Owen Clark, M. D., Milwaukee

2. EINAR R. DANIELS, M. D., Milwaukee: "Early Manifestations of Pulmonary Disease"

3. CARL W. EBERBACH, M. D., Milwaukee: "Hyperthyroidism: The Rationale of Modern Treatment"

4. W. S. MIDDLETON, M. D., Madison: "Newer Drugs and Their Uses"

5. JOHN C. PETERSON, M. D., Milwaukee: "General Principles of Fluid and Electrolyte Therapy in Infants and Children"

6. HERBERT W. POHLE, M. D., Milwaukee: "The Management of Hypertension"

7. GEORGE L. THOMAS, M. D., Janesville: "Fractures of the Os Calcis"

8. HERMAN H. SHAPIRO, M. D., Madison: "Home Management of Congestive Heart Failure"

9. W. D. STOVALL, M. D., Madison: "Viruses in Wisconsin: Their Recognition and Control by Immunization"

★

### *Special Luncheon*

10. PAST PRESIDENTS' LUNCHEON:
    All past presidents of the State Medical Society, the current president, and the current president-elect are to attend this luncheon.

★ ★

## *Special Entertainment:* DELEGATES AND EXHIBITORS

All delegates (with their wives) and exhibitors are to be entertained at the Blatz Brewing Company Auditorium at 7:30 to 10:00 p. m. on Monday, October 4. Following a program of music and light entertainment, a buffet supper will be served at 9:30 p. m. Because of limited facilities, only delegates and exhibitors can be accommodated.

# PROGRAM FEATURES

# TUESDAY OCTOBER 5

## *House of Delegates:* HOTEL SCHROEDER

In order to permit all members in attendance at the Annual Meeting to view the deliberations of the House of Delegates and hear the policy determinations made by House action, the second session of the House will be held in the Ballroom of the Hotel Schroeder at 7:30 p. m. on Tuesday, October 5. Members of the Woman's Auxiliary, as well as physician members, are urged to attend.

## *Scientific Programs:* MILWAUKEE AUDITORIUM

### 9:00–10:00 a. m.: DEMONSTRATIONS

Space S–28–29: **GROSS TISSUE: Wisconsin Society of Pathologists**
The demonstration consists of gross specimens, fixed and fresh, currently available and of special or general interest. They are drawn from surgical and autopsy cases.

Space S–33–34: **FRACTURE DEMONSTRATIONS: Wisconsin Orthopedic Society**
Special attention will be directed to handling of fractures of the shaft of the humerus by hanging cast method and also fractures of the ankle. Intramedullary nailing of the femur will also be discussed.

Space S–35–36: **THE POSTANESTHESIA RECOVERY ROOM: Wisconsin Society of Anesthesiologists**
This demonstration will be an exhibit of the equipment used in a postanesthesia recovery room and a demonstration and discussion of such equipment. Pictures of recovery rooms in various hospitals will be shown.

Space S–53–54: **THE CRANIAL CAVITY: Department of Anatomy, University of Wisconsin Medical School**
One specimen will show the cranial meninges, cerebral veins, fluid spaces, meningeal vessels, and dural sinuses. A second specimen will present a dorsal view of the brain stem and a complete laminectomy to show the roots of the cranial nerves and their relationships to other structures. The demonstrations are planned primarily for general practitioners confronted with cases of common head injuries.

Space S–55–56: **OB MANIKIN DEMONSTRATIONS: Wisconsin Society of Obstetrics and Gynecology**
Morning Demonstration: "Version Extraction and External Version": David J. Werner, M. D., Milwaukee

Afternoon Demonstration: "Management of Transverse Presentation and Breech Presentation": S. D. Austin, M. D., Green Bay

Space S–57–59: **MEETING THE NEEDS OF THE AMPUTEE: Ray Piaskoski, M. D., and Associates, VA Medical Center, Wood**
The demonstration will emphasize the teamwork concept of rehabilitation, including the part played by the physician, nurse, physical therapist, limb maker, and vocational counselor. Patients with amputations will be used for demonstrations.

### 10:00–11:30 a. m.: SPECIAL INTEREST PROGRAMS (See pages 515–516 for details)

PEDIATRICS . . . INTERNAL MEDICINE . . . RADIOLOGY . . . ORTHOPEDICS

### 12:15 p. m.: LUNCHEONS (See page 517 for details)

### 2:00 p. m.: GENERAL SCIENTIFIC ASSEMBLY: MILWAUKEE AUDITORIUM (See page 518)

### 2:30 p. m.: SPECIAL PROGRAM ON ANESTHESIA (See page 518)

*Tuesday*
*Oct. 5*

# ★ SPECIAL INTEREST PROGRAMS ★

*Note:* While the programs listed are in specialized fields, any members of the State Medical Society interested in the topics presented are urged to attend. Where business meetings of specialty groups are indicated, members of such societies are urged to remain after the scientific program has concluded.

■ ROBERT B. LAWSON, M. D.
Miami, Florida

## *Pediatrics*

WALKER HALL
MILWAUKEE AUDITORIUM

Moderator: E. H. Pawsat, M. D., Fond du Lac

■ ALBERT SCHROEDER, M. D.
Minneapolis

10:00 a. m.: THE TREATMENT OF VIRAL RESPIRATORY INFECTIONS
Robert B. Lawson, M. D., Professor of Pediatrics and Chairman of the Department of Pediatrics, University of Miami School of Medicine, Miami

10:45 a. m.: INFECTIOUS CROUP
Albert J. Schroeder, M. D., Clinical Instructor in Pediatrics, University of Minnesota Medical School, Minneapolis

(At the conclusion of the scientific meeting, there will be a short business meeting of the Wisconsin Chapter of the American Academy of Pediatrics)

■ WILLIAM B. BEAN, M. D.
Iowa City

## *Internal Medicine*

JUNEAU HALL
MILWAUKEE AUDITORIUM

Moderator: Herbert W. Pohle, M. D., Milwaukee

■ HANS SELYE, M. D.
Montreal, Canada

10:00 a. m.: THE GENERAL ADAPTATION SYNDROME
Hans Selye, M. D., Professor and Director of the Institute of Experimental Medicine and Surgery, Universite de Montreal, Montreal, Canada

10:45 a. m.: PAIN IN THE CHEST
*(The Lucy Ann Droessel Memorial Lecture, Wisconsin Heart Association)*
William B. Bean, M. D., Professor of Internal Medicine, State University College of Medicine, Iowa City

# Tuesday Oct. 5

■ DAVID G. PUGH, M. D.
Rochester, Minnesota

## Radiology

**NORTH KILBOURN HALL, MILWAUKEE AUDITORIUM**

Moderator: W. T. Clark, M. D., Janesville

10:00–10:10 a. m.: CORRELATION OF RADIOLOGIC AND SURGICAL-PATHOLOGIC FINDINGS IN PULMONARY TUBERCULOSIS
Charles E. Schmidt, M. D., Milwaukee

10:10–10:20 a. m.: ABNORMAL MASSES AT THE CARDIOHEPATIC ANGLE
Lester W. Paul, M. D., Madison

10:20–11:00 a. m.: SIMPLE BONE CYSTS, ANEURYSMAL BONE CYSTS, AND GIANT CELL TUMORS
David G. Pugh, M. D., Assistant Professor of Radiology, Mayo Foundation Graduate School, University of Minnesota, Rochester, Minnesota

11:00–11:10 a. m.: INTRACARDIAC GAS AS SIGN OF FETAL DEATH
Joseph Wepfer, M. D., Milwaukee

11:10–11:20 a. m.: A CASE REPORT OF TWO HEMANGIOMAS WITH LONG STANDING FOLLOW-UP
E. A. Pohle, M. D., and D. C. Ivie, M. D., Madison

11:20–11:30 a. m.: NODULAR DENSITIES OF THE LUNG
Theodore Pfeffer, M. D., Milwaukee

(Following the scientific program, there will be a short business meeting of the Wisconsin Radiological Society)

■ W. BRANDON MACOMBER, M. D.
Albany, New York

## Orthopedics

**SOUTH KILBOURN HALL**
**MILWAUKEE AUDITORIUM**

Moderator: Charles H. Ihle, M. D., Eau Claire

■ PAUL C. WILLIAMS, M. D.
Dallas, Texas

10:00 a. m.: THE CERVICAL SPINE
Paul C. Williams, M. D., Clinical Associate Professor of Orthopedic Surgery, Southwestern Medical School of the University of Texas, Dallas

10:45 a. m.: TREATMENT AND PREVENTION OF LATE CONTRACTURES OF THE HAND
W. Brandon Macomber, M. D., Associate Professor of Plastic and Reconstructive Surgery, Albany Medical College, Albany, New York

# ROUND TABLE LUNCHEONS

## *Tuesday, October 5*

*Note:* All luncheons listed will be held at the Hotel Schroeder from 12:15 until *1:30* p. m. Attendance is limited, so if you have not made your reservations, do so immediately. List three choices in order of preference. (At the time of publication, the luncheon of Doctor Selye is completely filled.) Cost: $2.50 per luncheon. Make your check payable to the State Medical Society of Wisconsin.

If any reservations remain, tickets can be secured in the fifth floor foyer of the Hotel Schroeder at 12:00 noon on the day of the luncheon.

1. JOHN ADRIANI, M. D., New Orleans: **"Obstetrical Anesthesia and Analgesia"**
   Chairman: L. F. Thurwachter, M. D., Milwaukee
2. WILLIAM B. BEAN, M. D., Iowa City: **"Clinical Vagaries of Myocardial Infarction"**
   Chairman: Francis Rosenbaum, M. D., Milwaukee
3. HARRY BECKMAN, M. D., Milwaukee: **"Recent Pharmacologic Developments of Clinical Interest"**
4. CHARLES W. CRUMPTON, M. D., Madison: **"Clinical Evaluation and Medical Treatment of the Hypertensive Patient"**
5. ALBERT FAULCONER, M. D., Rochester, Minnesota: **"What Is the Meaning of 'Depth of Anesthesia'?"**
   Chairman: W. H. Dornette, M. D., Madison
6. FRED W. FITZ, M. D., Chicago: **"Bedside Diagnosis and Treatment of Cardiac Arrhythmia"**
   Chairman: Lamont R. Schweiger, M. D., Milwaukee
7. ROBERT B. LAWSON, M. D., Miami, Florida: **"Antibiotic Therapy in Pediatric Practice"**
   Chairman: L. M. Simonson, M. D., Sheboygan
8. W. BRANDON MACOMBER, M. D., Albany, New York: **"The Treatment of Lower Leg Soft Tissue Deformities"**
   Chairman: Christopher R. Dix, M. D., Milwaukee
9. ALBERT J. SCHROEDER, M. D., Minneapolis: **"Erythroblastosis"**
   Chairman: Horace K. Tenney, M. D., Madison
10. DAVID G. PUGH, M. D., Rochester, Minnesota: **"Osteomalacia and Osteoporosis"**
    Chairman: S. A. Morton, M. D., Milwaukee
11. JAMES C. SARGENT, M. D., Milwaukee: **"Prostatism in Elderly Men"**
12. HANS SELYE, M. D., Montreal, Canada: **"The Use and Abuse of Cortisone and Allied Hormones in Clinical Medicine"**
    Chairman: A. W. Hilker, M. D., Eau Claire
13. PAUL C. WILLIAMS, M. D., Dallas, Texas: **"Choosing the Candidate for Lumbosacral Surgery"**
    Chairman: Herman W. Wirka, M. D., Madison

### *Special Luncheon*

Marquette Alumni Luncheon: Blatz Auditorium. (Do not make reservations for this luncheon through the State Medical Society but rather by writing Mr. Ray Pfau at the Marquette Alumni Association office, 1533 W. Wisconsin Avenue, or by phoning Mr. Pfau through Division 4–1000, Milwaukee)

### *Remember the Annual Dinner!*

**When making reservations for luncheons, remember the Annual Dinner, which will be held on Wednesday, October 6, as the concluding feature of the program. See page 523 for details. Cost: $6.50 per person, including dinner, entertainment, and the dance. Attendance is limited, so make your reservations early.**

# Tuesday Oct. 5

**2:00 p. m.: SECTION ON MEDICAL HISTORY: Pere Marquette Room, Hotel Schroeder**
Don McNeil, assistant director of the Wisconsin State Historical Society, will be the speaker. All members are urged to attend. The meeting will be under the direction of W. D. Stovall, M. D., chairman of the Section on Medical History.

**2:00 p. m.: GENERAL SCIENTIFIC ASSEMBLY: Juneau Hall, Milwaukee Auditorium**
MODERATOR: S. A. Morton, M. D., Milwaukee

2:00 p. m.: RECENT PROGRESS IN THE STUDY OF DISEASES OF ADAPTATION
Hans Selye, M. D., Montreal, Canada

2:30 p. m.: TREATMENT IN INFANCY AND CHILDHOOD
Robert B. Lawson, M. D., Miami, Florida

**3:00 p. m.: RECESS TO ATTEND DEMONSTRATIONS AND VIEW EXHIBITS**
DEMONSTRATIONS:
**Gross Tissue:** Wisconsin Society of Pathologists
**The Cranial Cavity:** University of Wisconsin Department of Anatomy
**Meeting the Needs of the Amputee:** VA Medical Center, Wood
**OB Manikin Demonstration: "Management of Transverse Presentation and Breech Presentation":** S. D. Austin, M. D., Green Bay
**The Postanesthesia Recovery Room:** Wisconsin Society of Anesthesiologists

SCIENTIFIC EXHIBITS
(See pages 524–526 for complete listing of scientific exhibits)

3:45 p. m.: THE TREATMENT OF MALIGNANCIES IN THE SPECIALTY OF PLASTIC SURGERY
W. Brandon Macomber, M. D., Albany, New York

4:15 p. m.: THE DOCTOR AND *HIS* HEART
Frederick W. Fitz, M. D., Chicago

## SPECIAL INTEREST PROGRAM

■ JOHN ADRIANI, M. D.
New Orleans

### *Anesthesia*

SOUTH KILBOURN HALL
MILWAUKEE AUDITORIUM

Moderator: L. F. Thurwachter, M. D., Milwaukee

■ ALBERT FAULCONER, M. D.
Rochester, Minnesota

2:00 p. m.: SILENT REGURGITATION AND ASPIRATION DURING ANESTHESIA
John Adriani, M. D., New Orleans

2:30 p. m.: ANESTHESIA EMERGENCIES THAT CONFRONT THE GENERAL SURGEON
Allen E. Talbot, M. D., Appleton

**3:00 p. m.: RECESS TO ATTEND DEMONSTRATIONS AND VIEW EXHIBITS**

3:45 p. m.: CARBON DIOXIDE GAS EXCHANGE IN THE BODY
Albert Faulconer, M. D., Head of Section of Anesthesiology, Mayo Clinic, Rochester, Minnesota

# PROGRAM FEATURES

# WEDNESDAY OCTOBER 6

## *House of Delegates:* HOTEL SCHROEDER

The third and final session of the House of Delegates will be held in the Ballroom, Fifth Floor, Hotel Schroeder, at 8:30 a. m.

## *Scientific Programs:* MILWAUKEE AUDITORIUM

### 9:00–10:00 a. m.: DEMONSTRATIONS

Space S–28–29: **GROSS TISSUE: Wisconsin Society of Pathologists**
The demonstration consists of gross specimens, fixed and fresh, currently available and of special or general interest. They are drawn from surgical and autopsy cases.

Space S–33–34: **FRACTURE DEMONSTRATIONS: Wisconsin Orthopedic Society**
Special attention will be directed to handling of fractures of the shaft of the humerus by hanging cast method and also fractures of the ankle. Intramedullary nailing of the femur will also be discussed.

Space S–35–36: **THE POSTANESTHESIA RECOVERY ROOM: Wisconsin Society of Anesthesiologists**
This demonstration will be an exhibit of the equipment used in a postanesthesia recovery room and a demonstration and discussion of such equipment. Pictures of recovery rooms in various hospitals will be shown.

Space S–53–54: **THE CRANIAL CAVITY: Department of Anatomy, University of Wisconsin Medical School**
One specimen will show the cranial meninges, cerebral veins, fluid spaces, meningeal vessels, and dural sinuses. A second specimen will present a dorsal view of the brain stem and a complete laminectomy to show the roots of the cranial nerves and their relationships to other structures. The demonstrations are planned primarily for general practitioners confronted with cases of common head injuries.

Space S–55–56: **OB MANIKIN DEMONSTRATIONS: Wisconsin Society of Obstetrics and Gynecology**
Morning Demonstration: "Manual and Forceps Rotation of the Occiput Transverse and Occiput Posterior Presentations and Positions": Russell Lewis, M. D., Marshfield

Space S–57–59: **MEETING THE NEEDS OF THE AMPUTEE: Ray Piaskoski, M. D., and Associates, VA Medical Center, Wood**
The demonstration will emphasize the teamwork concept of rehabilitation, including the part played by the physician, nurse, physical therapist, limb maker, and vocational counselor. Patients with amputations will be used for demonstrations.
**(No afternoon demonstrations as all exhibits down at 3:00 p. m.)**

### 10:10–11:30 a. m.: SPECIAL INTEREST PROGRAMS (See pages 520–521 for details)

OB & GYN . . . CARDIAC AND PULMONARY DISEASES . . . SURGERY

### 12:15 p. m.: LUNCHEONS: Hotel Schroeder (See page 522 for details)

### 1:30 p. m.: SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY (See page 521 for details)

### 2:30 p. m.: CLOSING SCIENTIFIC ASSEMBLY: Milwaukee Auditorium (See page 522 for details)

### 6:45 p. m.: ANNUAL DINNER: Hotel Schroeder

*Wednesday*
*Oct. 6*

# ★ SPECIAL INTEREST PROGRAMS ★

*Note:* While the programs listed are in specialized fields, any members of the State Medical Society interested in the topics presented are urged to attend. Where business meetings of specialty groups are indicated, members of such societies are urged to remain after the scientific program has concluded.

■ HOWARD J. TATUM, M. D.
New Orleans

## *Obstetrics and Gynecology*

JUNEAU HALL
MILWAUKEE AUDITORIUM

Moderator: W. V. Luetke, M. D., Madison

■ JOHN I. BREWER, M. D.
Chicago

10:00 a. m.: THE USES AND ABUSES OF OXYTOCICS IN OBSTETRICS
Howard J. Tatum, M. D., Associate Professor of Obstetrics and Gynecology, Louisiana State University Medical School, New Orleans

10:45 a. m.: CONSERVATISM OF THE OVARY
John I. Brewer, M. D., Professor of Obstetrics and Gynecology, Northwestern University School of Medicine, Chicago

(Following the conclusion of the scientific program, there will be a short business meeting of the Wisconsin Society of Obstetrics and Gynecology)

■ CHARLES CAMERON, M. D.
New York

## *Cardiac and Pulmonary Diseases*

WALKER HALL
MILWAUKEE AUDITORIUM

Moderator: Paul Hausmann, M. D., Milwaukee

■ THOMAS J. E. O'NEILL, M. D.
Philadelphia

10:00 a. m.: EPIDEMIOLOGIC AND LABORATORY EVIDENCE OF CAUSES OF LUNG CANCER
*(Lecture sponsored by Milwaukee and Wisconsin Divisions of The American Cancer Society)*
Charles S. Cameron, M. D., Medical and Scientific Director of The American Cancer Society, New York City

10:45 a. m.: INDICATIONS FOR HEART SURGERY
Thomas J. E. O'Neill, M. D., Assistant Clinical Professor of Surgery, Women's Medical College of Pennsylvania, and Associate Professor of Thoracic Surgery, Hahnemann Medical College, Philadelphia

*Wednesday Oct. 6*

■ HENRY DOUBILET, M. D.
New York

## *Surgery*

SOUTH KILBOURN HALL
MILWAUKEE AUDITORIUM

Moderator: P. A. Midelfart, M. D., Eau Claire

■ WILLIAM J. GROVE, M. D.
Chicago

10:00 a. m.: DIAGNOSIS AND TREATMENT OF RECURRENT PANCREATITIS
Henry Doubilet, M. D., Associate Professor of Surgery, College of Medicine, New York University, New York City

10:45 a. m.: THE USE OF ACTH AND CORTISONE IN SURGICAL PATIENTS
William J. Grove, M. D., Associate Professor of Surgery, University of Illinois College of Medicine, Chicago

■ GEORGE S. BAKER, M. D.
Rochester, Minnesota

## *Ophthalmology and Otolaryngology*

EAST ROOM
HOTEL SCHROEDER

Moderator: John W. Doolittle, M. D., Madison

■ JUSTIN M. DONEGAN, M. D.
Chicago

1:00 p. m.: Business meeting (following luncheon at 12:15 p. m.)

1:30 p. m.: RETROLENTAL FIBROPLASIA
Justin M. Donegan, M. D., Rush Associate Professor of Ophthalmology, University of Illinois College of Medicine, Chicago

2:10 p. m.: THE EVALUATION OF HEARING DISABILITY IN MEDICAL AND LEGAL CASES
Meyer S. Fox, M. D., Milwaukee

2:30 p. m.: RECENT ADVANCES IN THE TREATMENT OF RETINAL DETACHMENT
John B. Hitz, M. D., Milwaukee

3:00 p. m.: TREATMENT OF PAINFUL NEURALGIAS OF THE HEAD
George S. Baker, M. D., Assistant Professor of Neurosurgery, Mayo Foundation Graduate School, University of Minnesota Medical School, Rochester, Minnesota

# ROUND TABLE LUNCHEONS

## *Wednesday, October 6*

*Note:* All luncheons listed will be held at the Hotel Schroeder from 12:15 until 2:00 p. m. Attendance is limited, so if you have not made your reservations, do so immediately. List three choices in order of preference. Cost: $2.50 per luncheon. Make your check payable to the State Medical Society of Wisconsin.
If any reservations remain, tickets can be secured in the fifth floor foyer of the Hotel Schroeder at 12:00 noon on the day of the luncheon.
(The luncheon of Doctor Brewer is entirely filled).

1. JOHN I. BREWER, M. D., Chicago: **"Abnormalities of Menstruation"**
   Chairman: F. W. Hofmeister, M. D., Milwaukee
2. HENRY DOUBILET, M. D., New York: **"Status of Emergency Operation on the Acute Abdomen"**
   Chairman: Kenneth E. Lemmer, M. D., Madison
3. CHARLES S. CAMERON, M. D., New York: **"To Tell or Not to Tell" (The Cancer Patient)**
   Chairman: James E. Conley, M. D., Milwaukee
4. WILLIAM J. GROVE, M. D., Chicago: **"The Direct Surgery of Arteriosclerosis with Particular Reference to Abdominal Aortic Aneurysms"**
   Chairman: A. R. Curreri, M. D., Madison
5. OVID O. MEYER, M. D., Madison: **"Newer Drugs and Their Uses"**
6. FRANCIS D. MURPHY, M. D., Milwaukee: **"Cardiac Emergencies"**
7. HOWARD J. TATUM, M. D., New Orleans: **"Pregnancy Complicated by Heart Disease"**
   Chairman: W. V. Luetke, M. D., Madison
8. DONALD M. WILLSON, M. D., Milwaukee: **"Benefits and Hazards from the Administration of Potassium Salts"**

### *Special Luncheons*

9. Public Health: **"Viral Hepatitis"** with NED G. MAXWELL, M. D., Milwaukee, as discussion leader
10. Pathologists: GEORGE M. HASS, M. D., Chicago: **"Present Status of Human and Experimental Studies on the Pathogenesis of Arteriosclerosis"** (Followed by meeting of Wisconsin Society of Pathologists)
11. Section on **Ophthalmology and Otolaryngology:** Luncheon, followed by scientific program in same room. Speakers: JUSTIN DONEGAN, M. D., Chicago; GEORGE BAKER, M. D., Rochester, Minnesota; and DRS. MEYER FOX and JOHN HITZ, Milwaukee

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# CLOSING SCIENTIFIC ASSEMBLY

JUNEAU HALL — MILWAUKEE AUDITORIUM

Moderator: M. G. Rice, M. D., Stevens Point

2:30 p. m.: EVALUATION OF SURGICAL PROCEDURES IN UTERINE AND PERINEAL RELAXATION
John I. Brewer, M. D., Chicago

3:00 p. m.: CANCER: RESEARCH PROGRESS
Charles S. Cameron, M. D., New York City

3:30 p. m.: TEN-MINUTE RECESS

3:40 p. m.: THE PRESENT STATUS OF SURGICAL TREATMENT OF DUODENAL ULCER
Henry Doubilet, M. D., New York City

4:10 p. m.: THE SURGERY OF HEART DISEASE, EXCLUDING VALVULAR DEFECTS
Thomas J. E. O'Neill, M. D., Philadelphia

# Annual Dinner

BALLROOM OF THE HOTEL SCHROEDER

## WEDNESDAY—OCTOBER 6

Presiding Officer: H. Kent Tenney, M. D., President of the State Medical Society of Wisconsin

**Presidential Address** (15 minutes): H. Kent Tenney, M. D., Madison

**Address of the Incoming President** (15 minutes): Arthur J. McCarey, M. D., Green Bay

**Presentation of Certificates to New Members of the "50 Year Club":**

Albert Butler, Ashland
Leslie E. Coffin, Tucson, Arizona
Edward P. Crosby, Stevens Point
Otis H. Epley, New Richmond
B. O. Fosse, Beloit
P. H. Fowler, Plain
Maynord H. Fuller, Green Bay
Charles W. Giesen, Superior
Alexander F. Harter, Rhinelander
Harry J. Heeb, Milwaukee
John G. Hoffmann, Hartford
Nicholas J. Knauf, Chilton
William T. Kradwell, Wauwatosa
L. M. Lundmark, Ladysmith
Alfred C. Radloff, Plymouth
Bertha Reynolds, Avoca
John E. Schein, Oshkosh
M. M. Spitz, Milwaukee
Frank B. Taylor, Madison
David J. Twohig, Fond du Lac
Robert G. Washburn, Milwaukee
May R. Wells, Belleville, Illinois

**Entertainment:** Professional entertainment in the form of music and novelty acts will be featured for a full hour following the program listed above.

**Dance:** Following the professional entertainment and a short intermission period to clear the floor, dancing to the music of Steve Swedish and his orchestra will take place until midnight.

# SCIENTIFIC EXHIBITS

## *Reflect Varied and Significant Research of Wisconsin Physicians and Medical Groups*

The scientific exhibits listed below have been selected for the 1954 Annual Meeting by Dr. M. G. Rice, Stevens Point, a member of the Council on Scientific Work. The exhibits will be open in Bruce Hall of the Milwaukee Auditorium from 9:00 a.m. to 5:00 p.m. on Monday, October 4, from 8:00 a.m. to 5:00 p.m. on Tuesday, October 5, and on Wednesday, October 6, from 8:00 a.m. until 3:00 p.m.

Provision has been made on the time schedule so that these fine exhibits can be studied in the early morning hours before the formal scientific meetings and at the close of the morning sessions before lunch, as well as during a special recess period in the afternoon. The Council on Scientific Work appreciates the effort which went into the preparation of these exhibits and recommends that all physicians attending the Annual Meeting study their content and discuss the material with those in attendance.

### A. Fifth Street Foyer and Juneau Hall: Milwaukee Auditorium

**S-1, 2, 3 NEW SCIENTIFIC FILMS ON CANCER**

**American Cancer Society, Milwaukee and Wisconsin Divisions**

Special films of professional interest, prepared and available through the American Cancer Society, will be shown each day during the scientific programs and recess periods so those not interested in the specific papers presented can view these films. The "theatre" will be located in the foyer immediately adjacent to the main meeting hall.

As a corollary of the showing of cancer films, a special exhibit on lung cancer will be provided on the side of the "theatre" facing the foyer. The exhibit will show visually the four stages of carcinoma of the lung and the probable prognosis of each.

**S-4, 5 VASCULAR SURGERY AND THE ARTERY BANK**

**Department of Surgery, Marquette University School of Medicine, with the cooperation of Milwaukee County Hospital and Veterans Hospital, Wood, Wisconsin, E. A. Bachhuber, M.D., and James Sullivan, M.D., Milwaukee**

Indications for blood vessel grafting will be listed. Methods for collection and preservation of material for an artery bank and safeguards necessary will be described and illustrated where possible. Dog aortas with grafts of varying duration will be demonstrated. Actual case reports will be presented.

**S-6, 7 COLUMBIA HOSPITAL MEDICAL STAFF**

**Milwaukee, Wisconsin**

The exhibit is made up of graphic representations of work in subjects of special interest performed by various members of the hospital staff.

*Non-Tuberculous Acid-Fast Bacillus Infections of the Lung:* Dann B. Claudon, M. D.

*Plethysmography in Vascular Diseases:* James E. Conley, M. D.

*Cyclic Changes in Cervical Mucus:* Benjamin E. Urdan, M. D.; Alvin M. Kurzon, M. D.

*Anticoagulant Therapy:* John O. Chamberlain, M. D.; Fred W. Madison, M. D.

*Porphyrinuria in Lead Poisoning:* Elston L. Belknap, M. D.; Margaret C. Perry, M. A.

*Paper Electrophoresis:* Robert R. Koenig, M. D.; Benedict M. Polcyn, M. D.; Gorton Ritchie, M. D.

**S-8 THE HUMAN HEART**

**Wisconsin Heart Association**

The Wisconsin Heart Association display will feature a set of models of the healthy and diseased heart, which were prepared by medical sculptor, Abram Belskie. These life-size hearts show the configuration and relative position of the heart as seen in a roentgenograph. Included in the set are models of an average normal heart, transverse heart, vertical heart, three models of hearts with mitral stenosis, aneurysm of the aorta, casts of the chambers and great vessels, hypertensive heart, cor pulmonale.

**S-9 EPILEPSY AS TREATED AT MILWAUKEE CHILDREN'S HOSPITAL**

**F. J. Millen, M.D., Milwaukee Children's Hospital and Marquette University**

The exhibit will contain placards indicating statistical and general facts, as well as some specific data, concerning epilepsy in children. Electroencephalograms, x-rays, pneumoencephalograms, and arteriograms are shown as part of the work-up of the case of an epilcptic child. Differential diagnosis and clinical work-up, as well as the

mechanisms of an epileptic clinic in handling a child, are described. Modern drug therapy and its indications are included.

**S-10 A COMMON CAUSE OF PAINFUL SHOULDER: SUPRASPINATUS TENDINITIS**

**Mark W. Garry, M. D., and Mark J. Cicantelli, M. D., VA Center, Wood, Wisconsin, and Marquette University School of Medicine**

A frequently overlooked cause of painful shoulder is supraspinatus tendinitis. This rather common affection can be treated simply and effectively if recognized early; failure to identify it results in stubborn disabilities. Charts, line drawings, and photographs will be used to present clearly the diagnostic highlights and therapeutic regimen for this disorder.

**S-11 NEW NEUROSURGICAL PROCEDURE FOR RELIEF OF PAIN**

**David Cleveland, M. D., VA Center, Wood, Wisconsin, and Marquette University School of Medicine**

Stereoscopic slides and drawings to demonstrate modern and newer neurosurgical operations.

**S-13, 14 MINIFILMS MAY SUGGEST PULMONARY DISEASE**

**Wisconsin Anti-Tuberculosis Association, Deaconess Hospital, and Westinghouse Corporation**

Patients entering general hospitals for diagnosis and therapy should receive at least a miniature chest x-ray film. Frequently, cardiac abnormalities, carcinoma, tuberculosis, or other pulmonary pathology are suggested. 14 x 17 inch films and a brief history will help demonstrate the value of this procedure for routine hospital admissions.

**S-15 GRANULOMATOUS TUMORS AND SIMILAR PULMONARY LESIONS**

**VA Center, Wood, Wisconsin, and Marquette University School of Medicine, T. J. Pfeffer, M. D.**

Reproductions of chest films showing various pulmonary lesions which may be classified by the pathologist as granulomatous processes. One or more examples of pulmonary lesions simulating granulomas will also be shown.

**S-16 VIRUS AND RICKETTSIAL DISEASES**

**State Laboratory of Hygiene, University of Wisconsin, and State Board of Health, Madison**

There will be a presentation by chart of some of the common virus and rickettsial diseases which occur in this country, some of them in Wisconsin. The presentation will give a short description of the disease, the laboratory methods that are used for its recognition, the kind of specimens that are required to make the determinations, and how they should be collected and sent to the State Laboratory of Hygiene. The presentation will cover virus diseases of the respiratory tract and central nervous system, rickettsial diseases, and others. The charts will be concise, in small groups, and easily read; and at the booth there will be mimeographed sheets of the presentation that will be distributed. In addition, there will be a continuous slide presentation of two representative diseases—respiratory and central nervous system disease.

**S-17, 18 PULMONARY FUNCTION AND ANESTHESIA IN THORACIC SURGERY**

**VA Hospital, Madison**

The exhibit consists of three sections: Pulmonary Function, Anesthesiology, and Surgery.

Section One demonstrates the normal and abnormal spirograms of vital capacity, maximum breathing capacity, and the nitrogen meter tracings of the single breath $0_2$ test and the residual air studies.

Section Two demonstrates problems in anesthesia. Methods are shown for controlling oxygenation, elimination of carbon dioxide, and maintenance of circulation. The use of the Carlen intratracheal tube and the control of respiration to aid the thoracic surgeon are shown.

Section Three consists of several case reports illustrating the function studies, the x-rays, and the pathology of the resected lesions.

**S-19 PATHOLOGY OF BRONCHIAL ASTHMA**

**S. B. Crepea, M. D., University of Wisconsin Medical School**

Color slides illustrating the changes in seriously ill asthma patients will be shown. Correlation between the pathological changes and the necessary symptomatic therapy will be made.

**S-20, 21 HYDROCEPHALUS**

**Henry M. Suckle, M. D., Madison**

The newer diagnostic methods to determine the type of hydrocephalus and also the treatment are presented. The basic types of hydrocephalus will be demonstrated, and the available methods of treatment will be illustrated.

**S-22 DIAGNOSTIC AIDS IN CONGENITAL AND ACQUIRED HEART DISEASE**

**Departments of Medicine, Radiology, and Surgery, University of Wisconsin Medical School**

Angiocardiograms and cardiac catheterization results, including pressure changes before and after surgery, will be presented. The value of these tests in quantitating the degree of cardiovascular abnormalities, as well as in establishing the specific diagnosis, will be graphically presented. Their value as an aid toward disposition of the cardiac patient will also be evaluated.

## B. Bruce Hall (Exhibit Hall): Milwaukee Auditorium

**S-26, 27 PRACTICAL BALLISTOCARDIOGRAPHY**

**R. Rice, M. D., T. Calvy, M. D., I. Waldman, M. D., Regional Office, Veterans Administration, Milwaukee**

A report on a two-year experience with the Dock, Arbeit, and Glennite ballistocardiographs will be presented. Attempts at recording displacement, velocity, and acceleration ballistocardiographic tracings will be detailed; and the practical difficulties encountered due to instrumentation will be noted.

Errors in identifying individual components of ballistocardiographic curves with integrated, superimposed electrocardiograms will be demonstrated.

S-30, 31 RESPIRATORY ALLERGIES IN THE FARM POPULATION

Leon Unger, M. D., Albert H. Unger, M. D., Tybee Sue Meyers, M. T.

In a series of 86 patients coming from farm areas, it was found that a large percentage gave positive tests for allergens which are primarily from farm products. In addition, a great number were found allergic to ragweed and other allergens. Very satisfactory results have been obtained by the specific measures of avoidance and hyposensitization. Photographs and charts illustrate the main findings.

S-32 A POSITIVE PROGRAM FOR THE MANAGEMENT OF THE MULTIPLE SCLEROTIC

Edward P. Roemer, M. D., Madison

The exhibit portrays steps suggested in the management of a case of multiple sclerosis, a program based on empirical methods. The program includes recognition, diagnosis, classification, medical regime, physical medicine program, psychotherapy, vocational counseling, vocational training, and job placement.

S-37, 38 AUDIO-DIGEST FOUNDATION

A professionally sponsored service offering tape recorded medical literature by subscription. Profits are contributed to the nation's medical schools through the American Medical Education Foundation.

S-39-42 TESTING THE DRINKING DRIVER

American Medical Association

Three-dimensional figures portray (1) progressive degrees of intoxication, (2) amount of alcohol required to produce different stages of drunkenness, and (3) the corresponding anatomical portions of the brain that are anesthetized by the ingestion of alcohol. Lifelike, actual size reproductions of the brain are colored to show those portions which are affected in different stages of intoxication. The percentage of blood alcohol for each of the stages of intoxication is also shown.

PHYSICIAN RESPONSIBILITIES IN HIGHWAY ACCIDENTS

American Medical Association

The exhibit emphasizes the responsibility of the physician in advising his patient about driving a motor car. This will include advice about physical and mental conditions that preclude all driving, as well as about instances following the administration of certain anesthetics and drugs when the patient should refrain from driving for a certain number of hours.

S-43 ETIOLOGY OF MALPRACTICE

American Medical Association

This is an exhibit fom the Bureau of Legal Medicine and Legislation, Committee on Medicolegal Problems. The exhibit portrays situations which might give rise to suits for malpractice against a physician. Warning admonitions are included.

The exhibit consists of two transparency cases, each containing eleven transparencies. One set of illuminated transparencies is entitled, "Asking for Suit"; the other set is devoted to the subject of "Consent for Operation." The center portion of the exhibit is devoted to the subject of "General Plan." Thirteen questions are found on the face of the panel; and by lifting small panels, the answer to each question is found beneath.

S-44, 45 DIAGNOSIS AND TREATMENT OF GOITER

Arnold Jackson, M. D., Jackson Clinic, Madison

The exhibit demonstrates points in the diagnosis of various types of goiter: colloid, adenomatous, intrathoracic, malignant, toxic nodular, and exophthalmic.

S-46, 47, 48 SECTION ON RADIOLOGY

Section on radiology will consist of demonstration exhibits prepared by various practicing radiologists throughout the state of Wisconsin for purposes of demonstrating some newer radiological technics used in diagnosis and to describe radiological technics in diagnosis of various diseases, with the x-ray findings pertinent to these diseases. The purpose of this demonstration is to present to the medical profession the interesting radiological facts not on the radiological level entirely, but for the general medical profession at large.

S-49, 50 MECHANICAL QUACKERY

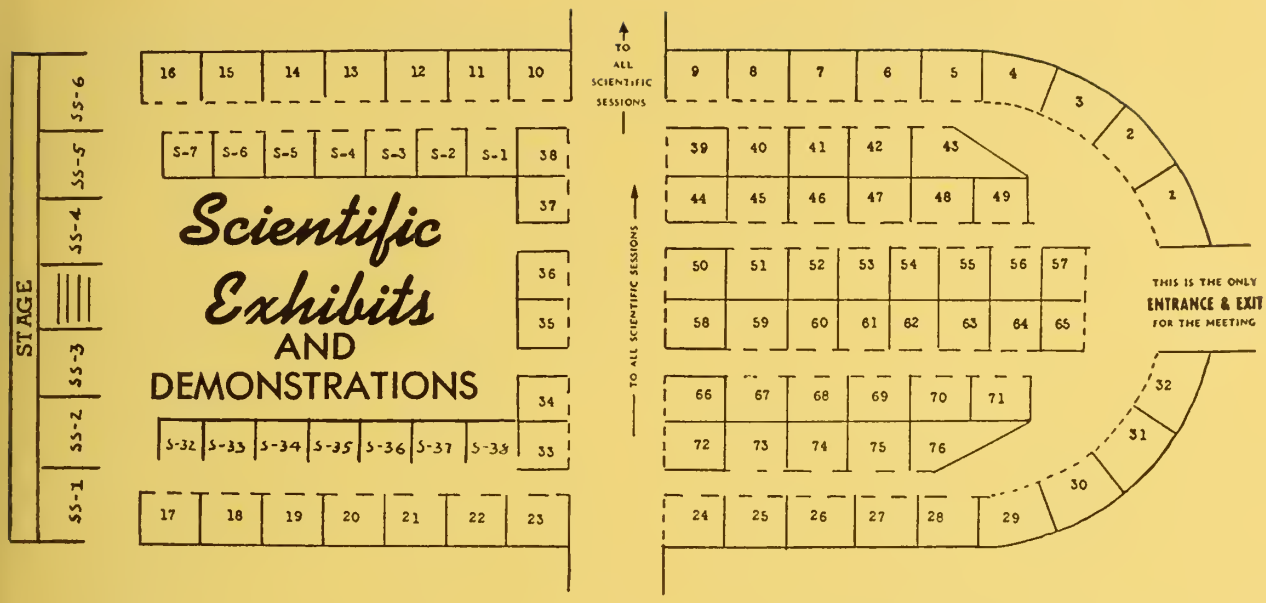
American Medical Association

This is an exposé of mechanical quackery from the Bureau of Investigation of the American Medical Association. Everything from a "magic horse collar," claimed to magnetize the iron in the blood, to a radioactive "rejuvenator" is presented by display of the actual quack device. Many other weird and humorous fake gadgets are shown. An extensive information file is incorporated as a part of the exhibit and contains descriptions and information concerning many more mechanical gadgets.

S-51, 52 PREPARATION AND USE OF PLACENTAL SERUM

C. F. McDonald, M. D., and L. J. Van Hecke, M. D., for the Wisconsin Academy of General Practice

Human placental serum can be easily collected and prepared for therapeutic use in the obstetrical division of any hospital. Originally the physicians exhibiting conjectured that the cells of the placenta should have teleological objectives of striving toward normality in the creation of a new being, sometimes within the structure of a very abnormal mother. If this were true, these cells should be expected to be a source of great creative, protective, and corrective potential. The serum's therapeutic use has shown effectiveness in certain disorders of hypersensitivity and poor response.




# TECHNICAL EXHIBITS

**Booth** — **Company and Products**

**37 Abbott Laboratories, North Chicago, Ill.**

The Abbott exhibit will feature *Nembutal*(R), a short-acting barbiturate with a wide range of uses. *Nembutal* can produce any desired degree of cerebral depression with only about one-half the dosage required with many other barbiturates. Among the *Nembutal* products to be displayed will be capsules, tablets, elixirs, suppositories, solutions, and sterile powder for solutions.

**54 A. S. Aloe Company, St. Louis**

Visit Booth 54, where the Aloe representative will show you a cross section of the complete line of physician's equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline—tomorrow's treatment room furniture today—featuring the body contour table top, magnetic door catches, and advanced design—all in new decorators' colors.

**17 Americana Corporation, Grand Rapids**

All members and guests of the State Medical Society of Wisconsin are invited to visit Booth 17 to inspect the new 1954 edition of the *Encyclopedia Americana* and the heritage edition of the *Book of Knowledge*.

**22, 73 American Hospital Supply Corporation, Evanston, Ill.**

*Booth 22*—Scientific Products Division, American Hospital Supply Corporation, will exhibit the fully automatic *Coreco Flash Clinical Camera* for technically and clinically accurate photographs of any body surface or cavity. With the *Coreco Camera*, you get automatic focusing and aperture setting, control of quantity and color value of flash bulbs, selector for black and white and color films, center view finder, flash bulb ejector, even and correct illuminating for all subject matter, and precalculated correct depth of focus for all subjects. In addition, we will show a number of new Clinical Laboratory Products.

*Booth 73*—Scientific Products Division, American Hospital Supply Corporation, will have on display the complete line of Baxter intravenous solutions and accessory sets, including the new electrolyte solutions, as well as *Gentran*, an effective, proved plasma volume expander for use in the treatment of shock, and the new *Plexitron Blood Pump* for safe, rapid pressure transfusions with expendable equipment.

**68 Ames Company, Inc., Elkhart, Ind.**

*Clinitest*, for urine-sugar analysis, is standardized. This assures uniformly reliable results whenever and wherever a test is performed—office, ward, clinic, or patient's home. Standardization not only curtails error but also saves personnel's time by elimination of preparing and mixing of reagents.

*Acetest* for acetonuria, *Bumintest* for albuminuria, *Hematest* for occult blood, and *Ictotest* for bilirubin will also be on display.

**19 Association Conventions Exhibits, New York**

**66 Ayerst Laboratories, New York**

We take great pleasure in extending a cordial invitation to all physicians attending the Annual Meeting to visit Booth 66. Our medical representatives will be pleased to discuss with you *Trilene, Antabuse, Premarin,* and other products of our manufacture.

**75 Baby Development Clinic, Chicago**

Maternity Counseling Service offers demonstration material to aid in teaching expectant

Booth Company and Products

mothers: care and support of breast; support of abdomen and relief of back strain; care of the skin. Preparation for infant and child care aids on bathing, feeding, sleeping, toileting will be presented. Material is also available for Well-Baby Conferences.

**55 The Baker Laboratories, Inc., Cleveland**

You are cordially invited to visit our booth, where medical service representatives will be glad to discuss with you the clinical application of *Baker's Modified Milk* and *Varamel,* two outstanding products that are making new progress in successful infant feeding.

**32 Barr X-Ray Company, Inc., Milwaukee**

The welcome mat again will be out at our usual place, first booth to the left as you enter the Exhibit Hall. Several changes have been made in our growing organization which will better enable us to serve you, our friends of the Medical Society. We invite you to become better acquainted with us. So if you have any x-ray problems to discuss or if you want to "just talk," stop and visit with us. We will do our best to accommodate, and look forward to meeting you.

**74 Beech-Nut Packing Company, New York**

Have you used the Beech-Nut Strained and Junior Foods for your *Geriatric* as well as your *Pediatric* patients? Beech-Nut nutritionists will be present to answer any questions you may have regarding the products available for special feedings.

**45 N. P. Benson Optical Company, Minneapolis**

On display will be a complete line of the most modern in style and design in ophthalmic eye wear. A complete line of new style Cataract lenses, along with other complicated types of lenses and multifocals, will be shown. New instruments will be displayed and complete information on these items of equipment and instruments given. There will be a display of prosthesis and complete information in regard to prosthesis work—service, as well as on contact lenses. Come in and discuss your optical problems with us. We will do our best to be of assistance to you.

**S-7 House of Bidwell, Inc., Milwaukee**

The display will include orthopedic, prosthetic, and surgical appliances, including the latest developments on upper extremities as presented by the National Research Council.

**67 Bilhuber-Knoll Corp., Orange, N. J.**

The written prescription bespeaks the physician's treatment of the patient. The medicinal chemicals of Bilhuber-Knoll Corporation merit your study and use in your daily practice. These prescription chemicals will be on display at Booth 67: *Bromural*—sedative, mild hypnotic; *Dilaudid*—analgesic, cough sedative; *Metrazol*—analeptic, tonic; *Octin*—antispasmodic; *Quadrinal*—antiasthmatic; *Tensodin*—coronary insufficiency; and *Valoctin*—sedo-spasmolytic.

**38 The Borden Company, Prescription Products Division, New York**

There's no better place to talk over the latest information on infant feeding than the Borden Prescription Products booth. On display is the complete line of Borden infant formula products for every feeding purpose or preference. If you're encountering hyperirritability or excoriation, you'll be interested in *Bremil,* a formula patterned upon breast milk. If you suspect milk allergy in some of your patients, you'll find the answer in either liquid or powdered *Mull-Soy,* leading hypoallergenic food. For prematures, or for digestive disturbances demanding low fat and high protein, *Dryco* provides an ideal, flexible formula base. And if your preference is for liquid products, you'll want the latest facts about *Biolac.*

**S-36 Brook Hill Farms, Chicago**

Samples of all Brook Hill dietary milks will be served. These include *certified Enzylac milk, goat milk, Dari-Vi (homogenized vitamins), certified fat free Enzylac milk, kazol-acidophilus buttermilk,* and *Bac-T (sweet skimmed acidophilus milk).* Brook Hill Farms products are distributed by all dairies in the Milwaukee and Chicago metropolitan areas. Our Brook Hill representatives will be on hand to welcome you.

**46 Brooks Appliance Company, Chicago**

The Brooks Appliance Company will exhibit and describe in detail the technic of applying combination pressure bandages. The moist medicated *Primer Bandage* and the *Dalzoflex Elastic Adhesive Bandage,* which are used in treating leg ulcers and phlebitis, will be shown. Elastic stockings, the *Nulast Elastic Crepe Bandage,* and surgical instruments will also be displayed.

**56, 76 Brown and Williamson Tobacco Corporation, Louisville**

*Booth 56*—Many members of the medical profession are showing unusual interest in KOOL (mildly mentholated) Cigarettes, for which there is a wide and growing acceptance among smokers troubled with throat irritations or respiratory disorders. Members who visit the KOOL exhibit will receive an attractive souvenir and a folder of interesting facts relating to the application of cooling menthol to tobacco.

*Booth 76*—The new King-Size VICEROY Filter Tip Cigarette gives the smoker *Double the Filtering Action* to double his smoking pleasure. There are 20,000 tiny filter traps in VICEROY'S new filter of pure, nonmineral *Estron.* It filters the smoke, yet draws freely and gives the smoker the full, rich taste of choice tobaccos. An explanation of the unique advantages of VICEROY will greatly interest members and guests who visit the VICEROY exhibit.

**39 Burroughs Wellcome & Co., Inc., Tuckahoe, N. Y.**

*Neosporin*(R), brand polymyxin B—bacitracin-neomycin.

Antibiotic Ointment—Wherever there is topical bacterial infection.

*Marezine*(R), hydrochloride brand cyclizine hydrochloride, controls:—Nausea and vomiting of pregnancy, motion sickness, vertigo.

*Syrup of Antepar*(R), citrate brand piperazine citrate. To eradicate pinworms and roundworms. Pleasant to take. Quickly effective.

**SS-1 Cameron Specialty Company, Chicago**

See the new Cameron holder-handle type cauteradio and other electro-surgical units, including suction coagulator and numerous other accessories for all phases of surgery, cauterization, coagulation, desiccation, and fulguration; electro-diagnostic lamp and instrument outfits; the new stainless steel Boros flexible esophagoscope and other peroral endoscopic equipment;

Booth — Company and Products

Coagulair and Dualite sigmoidoscopes; Tele-Vaginalite; other illuminated specula, endoscopes, and retractors; new mirror-type headlites and binocular spectacle loupes; flexible gastroscopes and stomach camera.

**S-34 S. H. Camp and Company, Jackson, Mich.**

S. H. Camp & Company will display the latest developments in scientifically designed anatomical supports and plastic braces. Ask to see the pelvic traction belt, diaphragmatic support with inflatable pad, contour cut rib belts made of foam rubber vulcanized on white tackle twill. See the new lightweight maternity girdles. Investigate to see how Camp supports can best meet your exacting requirements with patient comfort. Experts from the Camp staff will be on hand to answer your questions.

**71 Carnation Company, Los Angeles**

You are cordially invited to visit Booth 71, where you will see an attractive animated display illustrating the reasons why *Carnation Evaporated Milk* deserves consideration as your first choice for infant formulas. Carnation medical specialists will answer all questions on our sole processing and sterilization techniques.

**S-35 The Chicago Dietetic Supply House, Inc., Chicago**

You are cordially invited to visit Booth S–35, where the most complete line of Special Dietary Foods, under the *Cellu* label, are displayed for *sodium-restricted, sugar- and starch-restricted, low-calorie, and allergy diets.*

**58 Ciba Pharmaceutical Products, Inc., Summit, N. J.**

Ciba's exhibit features *Apresoline,* an effective antihypertensive agent that brings about gradual and sustained lowering of abnormally high blood pressure, increases blood flow through kidneys, and relaxes cerebral vascular tone.

**SS-2 Coca Cola (LaSalle) Bottling Company, Milwaukee**

**S-37 Eaton Laboratories, Inc., Norwich, N. Y.**

For prompt results in urinary tract infections, *Furadantin*(R) N.N.R. is now available in the form of tablets and as *Furadantin Pediatric Suspension* N.N.R. The latter consists of *Furadantin* suspended in a palatable, water-miscible gel with a pleasant custard flavor. Within 30 minutes after ingestion of this drug, the urine becomes strongly antibacterial.

Dosage forms of *Furacin*(R) of special interest include *Furacin Ophthalmic Liquid* N.N.R. and *Furacin Ophthalmic Ointment* N.N.R. for the rapid control of external ophthalmic bacterial infections and *Furacin Anhydrous Ear Solution* N.N.R. for otitis media et externa.

For the determination of bacterial sensitivity in agar cup plate tests, we now have available *Furadantin Diagnostic Tablets* and *Furacin Diagnostic Tablets.*

**8 H. G. Fischer & Company, Franklin Park, Ill.**

Latest models of modern x-ray, F.C.C.-approved physical medicine and rehabilitation equipment, all of highest quality materials and construction, will be on display. Representatives in attendance will welcome an opportunity to give demonstrations and quote today's prices. Your visit will be appreciated.

Booth — Company and Products

**72 C. B. Fleet Company, Inc., Lynchburg, Va.**

The C. B. Fleet Company cordially invites you to stop at Booth 72 to see the exhibit of *Phospo-Soda* (Fleet). *Phospo-Soda* (Fleet) is a solution containing in each hundred cubic centimeters 48 Gm. of sodium biphosphate and 18 Gm. of sodium phosphate. Over the years *Phospo-Soda* (Fleet) has won discriminating preference by thousands of physicians because of its controlled action . . . its freedom from undesirable side effects . . . and its ease of administration. There is only one *Phospo-Soda* (Fleet).

**18 Foldoor Sales Company of Wisconsin, Milwaukee**

**1 General Electric Company, X-Ray Department, Milwaukee**

The General Electric Company, X-Ray Department, is exhibiting the latest models in their electromedical line—the Model F Inductotherm and the DWB Cardioscribe. The Model F Inductotherm features built-in electrosurgical facilities, improved output, crystal-controlled frequency, and facilities for use of four types of electrodes. The DWB Cardioscribe, direct-writing electrocardiograph, features a new case for easier portability and operation, and a chest lead selector switch which enables the user to take up to 30 leads without changing electrodes.

**40 Gerber Products Company, Fremont, Mich.**

*When milk is contraindicated* as the basic food for infants, Gerber's "Meat Base Formula" can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. Your Gerber detail man invites you to evaluate "Meat Base Formula" and the complete line of supplementary baby foods.

You are also invited to review new editions of Gerber's baby care and adult special diet booklets. Each is designed especially for distribution by physicians. Each provides noncontroversial information in simple, easy-to-understand language. The service is complimentary.

**S-4 H. J. Heinz Company, Pittsburgh**

H. J. Heinz Company is the first to introduce strained meats in glass jars. They are the newest addition to the Heinz line of baby foods. Physicians and mothers alike are most happy to have strained meats in glass packages. Beef, liver, lamb, beef heart, pork, and liver and bacon are now available, with other meats to be added later.

These all-meat varieties, plus the other strained and junior foods, give the mother a complete line—over 50 varieties—of Heinz baby foods in glass jars.

Now, for your use, Doctor, there are nutritional data and variety and ingredient listing pads; and, for mother's use, there is literature about strained and junior foods.

**70 Hoffmann–La Roche, Inc., Nutley, N. J.**

**S-38 Horlicks Corporation, Pharmaceutical Division, Racine**

Horlicks Corporation, Pharmaceutical Division, introduces *Nulacin*—a unique milk-antacid tablet formulated to *dissolve slowly in the mouth.* Thus, *Nulacin* is the nearest approach to the continuous intragastric drip for the ambulatory patient in the treatment of peptic ulcer, gastritis, gastric hyperacidity, and pregnancy heartburn when due to hyperacidity.

Booth — Company and Products

**33, 34 Hurley X-Ray Company, Milwaukee**

You are cordially invited to visit our booths. Items of interest that are manufactured by Picker X-Ray Corporation and Burdick Corporation will be shown. This annual gathering is always a pleasant one for us. We have exhibited at most of your meetings since we started in business 31 years ago.

**29, 30 Karrer Company, Milwaukee**

Our outside representatives will welcome their friends at Booths 29 and 30, where the Karrer Company will display Hamilton, Allison, and Ritter medical furniture, and Liebel-Flarsheim short wave and electrosurgical units, ultraviolet and infra-red lamps, portable and cabinet sterilizers, autoclaves, basal metabolors, suction and pressure units, physicians' bags, centrifuges, diagnostic and surgical instruments, Vim syringes and needles, and many other new items.

**4 Kremers–Urban Company, Milwaukee**

Welcome to the K–U exhibit. Featured medications will include *Kused* for sedation without depression . . . *Kutapressin* for conditions associated with abnormally dilated arterioles and capillaries . . . *Salimeph–C* and *Phyatromine–H* for relief of pain and spasm in rheumatoid arthritis and related conditions . . . *OB–6* and *Rydiamin* for protection against pregnancy toxemias and relief of hyperemesis gravidarum.

**S-2, S-3 Laabs, Incorporated, Milwaukee**

**28 Lakeside Laboratories, Inc., Milwaukee**

Lakeside representatives will be on hand at the Lakeside Laboratories booth to discuss *Neohydrin, Mercuhydrin Sodium,* and other Council-accepted products, as well as research in various fields.

**64 Langer Laboratories, Inc., Milwaukee**

Once more we've got a handy booth
To greet each man, and handsome youth.
Once more we greet you with a line
That you'll agree is super-fine,
So make a note—pay us a call,
We're here to greet you—one and all.

**69 Lederle Laboratories Division, American Cyanamid Company, Pearl River, N. Y.**

**44 Eli Lilly and Company, Indianapolis**

You are cordially invited to visit the Lilly exhibit located in space number 44. The display will contain information on recent therapeutic developments and will feature the story of the Lilly Junior Taste Panel. Lilly sales people will be in attendance. They welcome your questions about *Ilotycin* (Erythromycin, Lilly) and other Lilly products.

**42 J. B. Lippincott Company, Philadelphia**

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

Booth — Company and Products

**SS-4 Loewi and Company, Milwaukee**

Information about investment securities will be given.

**S-32 P. Lorillard Company, New York**

P. Lorillard Company, manufacturers of OLD GOLD and EMBASSY Cigarettes, as well as BRIGGS Pipe Mixture and other famous tobacco products, will exhibit and demonstrate their new KENT Cigarettes with the exclusive *Micronite* Filter, which takes out up to 7 times more nicotine and tars than other filter cigarettes.

**21 Lov-é Brassiere Company, Hollywood, Calif.**

The Lov-é Brassiere Company will present their highly specialized line of breast supports. This company manufactures 18 separate and distinct models in a range of more than 500 sizes. All of these brassieres are custom fitted by highly trained brassiere experts. Special consultants in charge of the exhibit will be glad to explain how prescription instructions are followed to meet the patient's individual requirements.

The Lov-é line is featured in leading department stores and corset shops coast to coast. *Lov-é Brassieres* are represented in Milwaukee by the Dreyer–Meyer Corset Shop, 704 North Milwaukee Street, where a staff of trained fitters is available at all times.

**35 M & R Laboratories, Columbus, Ohio**

Your *Similac* representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of *Similac* in infant feeding. They have for you the latest Pediatric Research Conference Reports. Current reprints of pediatric nutritional interest are also available.

**SS-5 Maico of Madison, Madison**

Maico of Madison and Maico-Milwaukee, Inc., will show a full line of clinical audiometers and the new Maico *Stethetron*—a small portable electronic stethescope. The *Stethetron* is designed for use by the hard-of-hearing physician, the heart and lung specialist; it is capable of amplifying the low frequency sounds of the heart and chest not heard by the normal human ear. It is also helpful to the obstetrician and general practitioner in diagnosing certain fetal movements.

**26 Mead Johnson and Company, Evansville, Ind.**

Mead Johnson and Company will display the following products: *Lactum* (powdered and liquid forms), Mead's nutritionally sound formula for infants; *Liquid Sobee,* a hypoallergenic soya formula (milk-free); *Lytren;* oral electrolytes; *Poly-Vi-Sol; Tri-Vi-Sol;* and *Mulcin.*

**13 Medco Products Company, Tulsa, Okla.**

The *Medcolator* Stimulator, for the stimulation of innervated muscle or muscle groups ancillary to treatment by massage, is a low-volt generator that will generate plenty of your interest. Electrical muscle stimulation is a valuable form of rehabilitation therapy. Be sure to visit our booth for a personal demonstration.

**SS-6 Medical Electric Company, Milwaukee**

North American Philips x-ray therapy and diagnostic equipment will be displayed, along

Booth Company and Products

with processing, protective, and research accessories of other well-known manufacturers such as Brady, Buck, Fairchild, and Kodak. Medical Electric Company as authorized dealer also offers a complete line of North American Philips tubes.

**6 Medical Protective Company, Fort Wayne, Ind.**

The know-how in defense and proved protection against loss that have made the Medical Protective Company pre-eminent in the professional liability field through more than half a century now add new luster to the Company's time-tested individual plan of professional protection in the face of severe underwriting difficulties prevailing elsewhere. Authoritative answers to questions arising out of the doctor-patient relationship may be obtained at Booth 6 from the company's representative, who has had the special training and long experience that prove so advantageous in this field.

**23 Medico-Mart, Inc., Milwaukee**

**65 The Wm. S. Merrell Company, Cincinnati, Ohio**

*TACE*, the unique non-steroid developed by Merrell, *offers a new approach to the treatment of the menopause.*

*TACE* is temporarily stored in body fat and released over an extended period of time. One course of *TACE* therapy is generally all that is required to ease many patients into the symptom-free postmenopausal period. Symptom relief is excellent, and side effects are virtually absent.

Merrell professional service representatives will be present to answer any questions you may have concerning this new and distinctive estrogen. They will be happy to discuss other Merrell specialties as well.

**S-1 Miller Surgical Company, Chicago**

Miller Surgical Company will show the Miller *Electro-scalpel.* This unit cuts, desiccates, fulgurates, coagulates, and is used for most delicate work up to light major surgery. It is an office unit, portable, with cords, handles, foot switch, and accessories such as insulated snares, smoke ejector, etc. Also, the company has a complete line of diagnostic equipment, consisting of illuminated otoscopes, ophthalmoscopes, eyespuds with magnet, transillumination lamps, headlights, and vaginal speculum with smoke eject. Other available equipment includes the Gorsch operating scopes and stainless steel proctoscopes, all sizes, with magnification, suction tubes, and grasping forceps.

**50 V. Mueller & Company, Chicago**

V. Mueller & Company will again display a complete line of surgeon's instruments. Many new items in the thoracic and cardiovascular line will be shown.

**20 The National Drug Company, Philadelphia**

You are cordially invited to visit the booth of The National Drug Company. The featured product will be *Parenzyme* (intramuscular trypsin). This product introduces a new era in medicine, that of clinical enzymology. *Parenzyme* (intramuscular trypsin) is a sesame oil suspension of the proteolytic enzyme, trypsin, that produces rapid, dramatic reduction in acute local inflammation in phlebitis (thrombophlebitis and phlebothrombosis); ocular inflammation (iritis, iridocyclitis, and chorioretinitis); and traumatic wounds. It is also effective in the treatment of leg ulcers (varicose and diabetic).

**11 A. R. Nechin Company, Chicago**

On exhibit will be the entirely new *Jones Air Basal.* This is a new concept in metabolism testing. No oxygen tanks or capsules are required. Oxygen from room air is used in making the metabolic determination. Also shown will be the *PC₃ Cardiotron,* a new model of the original direct-recording electrocardiograph, and the Teca low-voltage generators for nerve and muscle testing and stimulation.

**27 John Nichols, Inc., Milwaukee**

The compact, simple, "years-ahead" design of the Gray *Phonaudograph* increases efficiency, saves time and money. More dictation per dollar —that's what you get in Gray equipment. The low-cost *Phonaudograph III* system is the dictation method of the future—yours today. All the menial tasks incidental to mechanical dictation are eliminated; and, in lieu of a machine at your desk, you are now served by a foolproof phone, easy to handle and pleasant to use. You add dictation points in your office to system of *Phonaudograph* for only $56.50. See this equipment in Booth 27.

**49 Parke, Davis & Company, Detroit**

A cordial welcome awaits you at the Parke, Davis booth. Members of our medical service staff will be on hand to greet you and discuss any of our products in which you may be particularly interested.

**12 H. E. Pengelly X-Ray Company, Milwaukee**

The H. E. Pengelly X-Ray Company has been in the x-ray business since 1908, only 13 years after the discovery of x-ray by Professor Roentgen. We are distributors for Standard X-Ray Company, Continental X-Ray Company, all x-ray film manufacturers, and all accessory equipment makers. We also distribute physical therapy and hydrotherapy equipment.

**48 Pet Milk Company, St. Louis**

We will be pleased to have you stop and discuss the variety of timesaving material available to busy physicians. Our representatives will be on hand to discuss the merits of *Pet Evaporated Milk* in infant feeding and *Pet Nonfat Dry Milk* in special diets. A miniature can of *Pet Evaporated Milk* will be given to all visitors.

**31 Pfizer Laboratories, Chas. Pfizer & Co., Inc., Brooklyn**

You are cordially invited to visit the Pfizer booth. *Terramycin Intramuscular* holds the spotlight this year, with a star-studded cast which includes *Cortril* (brand of hydrocortisone) in several convenient dosage forms and the complete line of Pfizer–Syntex steroid hormones.

Another newcomer to the Pfizer display is *Bonamine,* the first compound effective against motion sickness in a single daily dose.

**3 Philip Morris & Co., Ltd., Inc., New York**

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration to show the difference in cigarettes will be made on smokers at the exhibit.

Booth — Company and Products

**62, 63 Physicians & Hospitals Supply Company, Inc., Minneapolis**

The Physicians & Hospitals Supply Company of Minneapolis invites you to visit Booths 62 and 63 to examine the latest in medical equipment, including the new F.C.C.-approved short-wave diathermy, a complete display of Swedish stainless steel instruments, Ulmer Pharmaceuticals, and many other new items of interest. Our representatives will be present at all times to discuss your requirements.

**16 Professional Business Service, La Crosse**

"Business efficiency experts for the medical office," is the description applied to this service by clients. Representatives will be at the booth to greet doctors and explain the scope of service available.

**24, 25 R. J. Reynolds Tobacco Company, Winston-Salem, N. C.**

Welcome to the R. J. Reynolds Tobacco Company exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, CAVALIER King Size, or WINSTON, the distinctive new king size, cork tip, filter cigarette.

**53 A. H. Robins Company, Inc., Richmond, Va.**

Physicians attending The State Medical Society of Wisconsin meeting are extended a cordial invitation to visit the exhibit of the products of the A. H. Robins Company.

Experienced medical representatives will be in attendance to welcome you and to answer inquiries relative to any of Robins' prescription specialties.

**43 Roemer Drug Company, Milwaukee**

It has been our pleasure to serve the medical profession since 1898. Our representatives will welcome their many friends at Booth 43, where we will show Hamilton furniture, sterilizers, basal metabolors, instruments, and many other items required by the physician.

**14 J. B. Roerig and Company, Chicago**

Members of the State Medical Society of Wisconsin are cordially invited to visit the booth of J. B. Roerig and Company. Professional service representatives will be on hand to welcome all interested visitors.

**52 Sandoz Pharmaceuticals, Hanover, N. J.**

It is with a great deal of pleasure and pride that we invite you to visit our exhibit at the forthcoming convention. Our representatives will gladly welcome you to Booth 52.

**57 W. B. Saunders Company, Philadelphia**

A few titles of special interest published since last year's meeting are Nelson—*Pediatrics*, Campbell—*Urology*, Flint—*Emergency Treatment and Management*, and A.M.A.—*Anesthesia*. These and many more will be available at our booth. Please stop by.

**9 Schering Corporation, Bloomfield, N. J.**

Members of the State Medical Society of Wisconsin and their guests are cordially invited to visit the Schering exhibit, where new therapeutic developments will be featured. Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

Booth — Company and Products

**10 G. D. Searle and Company, Chicago**

You are cordially invited to visit the Searle booth, where our representatives will be happy to answer any questions regarding Searle products of research.

Featured will be *Vallestril*, the new synthetic estrogen with extremely low incidence of side reactions; *Banthine*, and *Pro-Banthine*, the standards in anticholinergic therapy; and *Dramamine*, for the prevention and treatment of motion sickness and other nauseas.

**60 Sharp & Dohme, Division of Merck & Company, Philadelphia**

The many indications for *Hydrocortone* or *Cortone* highlight the therapeutic importance of these hormones in everyday practice. Research data relative to more effective therapy when penicillin is used in conjunction with *Benemid* probenecid completes the exhibit. Expertly trained personnel solicit discussion on these observations.

**S-33 S. & L. Signal Company, Inc., Madison**

The *S. & L. Enuresis Alarm* will be demonstrated. Representatives will be glad to discuss conditioned response therapy for functional enuresis, effective in 91 per cent of all cases so treated during the past five years.

*S. & L. Enuresis Alarms* are rented to patients on prescription only, at very reasonable rates, for use under the physician's supervision. They are A.M.A. accepted, and provide the following features: rugged construction, high moisture sensitivity, battery operation (no shock danger), "lock-up" triggering circuit, and extremely durable *Durcon* electrodes, providing unusual comfort and dependability.

S. & L. prescription rental service makes enuresis therapy a satisfying, not frustrating, experience.

**5 Smith, Kline & French Laboratories, Philadelphia**

The Smith, Kline and French booth will feature the latest clinical information about the remarkable new drug, *Thorazine**, and its many and varied uses. These uses include potent antiemetic action, potentiation of other drugs, and its unique and dramatic applications in the field of mental and emotional problems.

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* *Thorazine* — Trademark, Smith, Kline and French.

**51 E. R. Squibb & Sons, New York**

New Squibb products and new brochures of useful interest to you on products already introduced will be featured at Booth 51.

As in former years, your Squibb representative again cordially invites you to visit the Squibb booth.

**22 Terry Shoe Company, Milwaukee**

Our representative will be in attendance to show the complete line of *Sabel* shoes, the popular *Plumb Line* shoes, the utilitarian *Surgical* shoes, and the famous *Club Foot* shoes.

Featured in the *Sabel* line will be the new oxfords for rheumatoid arthritis and hallux valgus for women.

On display for the first time will be our new flexible shank and normal children's shoes which are made at the Child Life factory. We are prepared to meet all your orthopedic shoe problems.

Booth — Company and Products

**61 The Upjohn Company, Kalamazoo, Mich.**

The Upjohn exhibit will feature *Cortef,* brand of hydrocortisone. Reports from clinicians and practitioners reveal dramatic results in the use of *Cortef* where cortisone is indicated. *Cortef* is available in tablet or ointment form for oral or topical use. Upjohn representatives will welcome the opportunity to furnish additional information to the profession.

**41 U. S. Standard Products Company, Woodworth**

We will be on hand, as in former years, to greet our friends, displaying our highly standardized line of pharmaceuticals. Our representatives—your detail man—will give all information on our formulas.

**7 U. S. Vitamin Corporation, New York**

The exhibit features original, complete lipotropic therapy . . . *Methischol* . . . the combination of five proved lipotropic agents: $B_{12}$, choline, methionine, inositol, and liver extract, therapeutically effective in the treatment of hypercholesterolemia as associated with atherosclerosis; coronary disease; obesity; diabetes; and various forms of liver disease, including liver cirrhosis and toxic hepatitis.

The exhibit also features *Panthoderm Cream,* the new and strikingly effective anti-pruritic healing ointment. Dermatoses, long-resistant skin lesions, topical ulcers, and slow healing wounds show rapid clinical improvement; pain, itching, and irritation abate rapidly.

**47 Varick Pharmacal Company, Inc., New York**

E. Fougera & Company, Inc., and division Varick Pharmacal Company, Inc., cordially invite physicians to discuss with professional service representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

**SS-3 Warner–Chilcott Laboratories, New York**

Two important cardiovascular agents will be featured at the Warner–Chilcott booth: *Methium* —to lower blood pressure and relieve hypertensive symptoms—and *Peritrate*—to prevent attacks in angina pectoris. Representatives and research personnel will welcome an opportunity to discuss these drugs with you.

**15 Westinghouse Electric Corporation, X-Ray Division, Baltimore**

Westinghouse X-Ray Division of Milwaukee and Pengelly X-Ray Company of Minneapolis, Westinghouse X-Ray distributors, exhibit x-ray accessories and photographs of latest type of x-ray equipment available, including the new *Fluorex* or Image Amplifier, which permits "daylight" fluoroscopy.

**S-6 Wisconsin Alumni Research Foundation, Madison**

The Foundation has recently received the results of the clinical investigation of a new anticoagulant. This highly soluble compound, when given intravenously, induces a full therapeutic level of the prothrombin time in 20 to 24 hours.

The single dose of this intravenous anticoagulant is effective from four to six days. It may then be continued in tablet form or as the injectable form.

The effect of the salicylates on the pituitary adrenal system will be shown. The possible action on the hypothalamus and the resulting stimulation of pituitary and adrenal cortex produce similar results to ACTH and cortisone therapy. Aspirin in combination with Vitamin K and ascorbic acid gives the required therapeutic effect without the disadvantages.

**2 White Laboratories, Inc., Kenilworth, N. J.**

White's *Phonoscope* enables you to hear some of the heart sounds commonly encountered in clinical medicine and to see graphically displayed the associated electrocardiograms, carotid artery pulsations, and apical stethograms. *Gitaligin* (amorphous gitalin) which has been described as a ". . . digitalis preparation of choice" will be on display.

**38 Winthrop–Stearns, Inc., New York**

Winthrop–Stearns, Inc., extends a cordial invitation to visit Booth 36. Featured will be *Levophed Bitartrate,* the most powerful pressor antidote for shock due to myocardial infarction, surgical and nonsurgical trauma, hemorrhage, and other causes. *Levophed* is noted for its prompt, predictable, reliable, and easily controlled action. *Telepaque,* highly effective and well-tolerated oral cholecystopaque medium, gives more dense, clear-cut pictures of the gallbladder and, in a substantial number of cases, also permits visualization of the biliary ducts.

**S-5 Wyeth Laboratories, Philadelphia**

Wyeth will feature various forms and combinations of *Bicillin*(R), the relatively insoluble, long-acting penicillin compound: *Bicillin Injection* (several strengths) for treatment and prophylaxis of infections caused by penicillin-susceptible organisms; *Bicillin C-R* for use in general practice; *Bicillin All-Purpose* for prophylaxis and treatment of surgical infections; *Bicillimycin All-Purpose,* combination of *Bicillin,* procaine and potassium penicillins, plus dihydrostreptomycin and streptomycin, particularly effective against mixed or multiple infections; widely-prescribed *Bicillin Oral Suspension* and *Tablets Bicillin,* two useful, convenient oral forms which are resistant to degradation by gastric juice so hence may be given without regard to meals.

Also featured will be *Wydase*(R), the purified "spreading factor" hyaluronidase with a wide range of clinical applications.

**59 Zimmer Manufacturing Company, Warsaw, Ind.**

Zimmer Manufacturing Company will exhibit the new Robbins automatic regulated tourniquet, the new Robbins Circlecuf blood pressure unit, new rib splints, new head halters, new arm slings, and many other items from our complete line of fracture appliances.

# HOUSE OF DELEGATES—1954

**HOTEL SCHROEDER—Monday, Oct. 4, 9:00 a. m.—Tuesday, Oct. 5, 7:30 p. m.—Wednesday, Oct. 6, 8:30 a. m.**
**SPEAKER: L. O. Simenstad, M. D., Osceola—VICE-SPEAKER: J. W. Fons, M. D., Milwaukee**

## FIRST DISTRICT

| Counties | Delegates | Alternates |
|---|---|---|
| DODGE | A. B. Kores | L. W. Schrank |
| JEFFERSON | R. W. Quandt | F. A. Gruesen |
| WAUKESHA | M. J. Werra | W. D. James |

## SECOND DISTRICT

| | | |
|---|---|---|
| KENOSHA | D. N. Goldstein | L. H. Lokvam |
| RACINE | L. J. Kurten | G. N. Gillett |
| | L. E. Fazen, Jr. | R. J. Schacht |
| WALWORTH | E. D. Sorenson | E. D. Hudson |

## THIRD DISTRICT

| | | |
|---|---|---|
| COLUMBIA–MARQUETTE–ADAMS | J. H. Houghton | J. W. MacGregor |
| DANE | L. E. Holmgren | J. R. Steeper |
| | M. T. Morrison | J. A. Grab |
| | T. W. Tormey, Jr. | R. N. Allin |
| | C. W. Stoops, Jr. | R. F. Collins |
| | G. C. Hank | O. S. Orth |
| | A. A. Quisling | John T. Sprague |
| GREEN | W. D. Stovall, Jr. | D. E. Mings |
| ROCK | Richard A. Thayer | E. T. Rechlitz |
| | M. D. Davis | R. W. Farnsworth |
| SAUK | J. F. Moon | J. J. Rouse |

## FOURTH DISTRICT

| | | |
|---|---|---|
| CRAWFORD | O. E. Satter | T. F. Farrell |
| GRANT | K. L. Bauman | J. W. Conklin |
| IOWA | C. L. White | S. B. Marshall |
| LAFAYETTE | D. J. Garland | L. L. Olson |
| RICHLAND | D. J. Taft | R. E. Housner |

## FIFTH DISTRICT

| | | |
|---|---|---|
| CALUMET | E. W. Humke | A. C. Engel |
| MANITOWOC | E. C. Cary | R. G. Strong |
| SHEBOYGAN | P. B. Mason | F. A. Nause |
| WASHINGTON–OZAUKEE | P. B. Blanchard | E. C. Quackenbush |

## SIXTH DISTRICT

| | | |
|---|---|---|
| BROWN–KEWAUNEE–DOOR | L. C. Miller | P. F. Dockry |
| | R. M. Waldkirch | S. L. Griggs |
| FOND DU LAC | H. J. Kief | J. S. Huebner |
| OUTAGAMIE | G. W. Carlson | H. T. Gross |
| WINNEBAGO | R. H. Bitter | David Regan |
| | George Schwei | Warren V. Hahn |

## SEVENTH DISTRICT

| | | |
|---|---|---|
| TREMPEALEAU–JACKSON–BUFFALO | R. L. MacCornack, Sr. | F. C. Skemp |
| LA CROSSE | Robert L. Gilbert | R. W. Ramlow |
| MONROE | S. D. Beebe | Harry Mannis |
| VERNON | Frank Gollin | Edward Vig |
| JUNEAU | V. M. Griffin | |

## EIGHTH DISTRICT

| | | |
|---|---|---|
| MARINETTE–FLORENCE | C. E. Koepp | J. W. Boren, Jr. |
| OCONTO | H. A. Aageson | D. M. Bailey |
| SHAWANO | F. W. Henke | D. A. Jeffries |

## NINTH DISTRICT

| Counties | Delegates | Alternates |
|---|---|---|
| CLARK | M. V. Overman | |
| GREEN LAKE–WAUSHARA | H. C. Koch | Roy Hong |
| LINCOLN | R. G. Baker | K. A. Morris |
| MARATHON | E. P. Ludwig | D. M. Green |
| PORTAGE | A. G. Dunn | R. H. Slater |
| WAUPACA | M. A. Borchardt | F. J. Pfeifer |
| WOOD | R. W. Mason | W. L. Nelson |

## TENTH DISTRICT

| | | |
|---|---|---|
| BARRON–WASHBURN–SAWYER–BURNETT | N. A. Eidsmoe | W. B. Rydell |
| CHIPPEWA | W. C. Henske | J. J. Sazama |
| EAU CLAIRE–DUNN–PEPIN | R. J. Bryant | R. C. Strand |
| PIERCE–ST. CROIX | P. H. Gutzler | O. H. Epley |
| POLK | L. O. Simenstad | V. C. Kremser |
| RUSK | L. M. Lundmark | H. F. Pagel |

## ELEVENTH DISTRICT

| | | |
|---|---|---|
| ASHLAND–BAYFIELD–IRON | J. W. Prentice | J. M. Jauquet |
| DOUGLAS | Charles W. Giesen | F. W. Reibold |

## TWELFTH DISTRICT

| | | |
|---|---|---|
| MILWAUKEE | I. J. Ricciardi | H. J. Lee |
| | E. R. Daniels | E. P. Bickler |
| | F. E. Drew | G. E. Collentine, Jr. |
| | J. W. Fons | J. E. Conley |
| | J. G. Garland | J. P. Conway |
| | J. V. Herzog | D. V. Elconin |
| | S. W. Hollenbeck | M. S. Fox |
| | W. J. Houghton | P. F. Hausmann |
| | G. S. Kilkenny | G. W. Hilliard |
| | L. P. Stamm | R. L. Rice |
| | C. A. H. Fortier | J. M. Sullivan |
| | A. J. Baumann | R. A. Frisch |
| | J. B. Wilets | R. E. Callan |
| | R. F. Purtell | David W. Ovitt |
| | J. A. Enright | S. L. Chojnacki |
| | P. J. Niland | A. D. Kilian |
| | P. E. Oberbreckling | |
| | T. J. Aylward | D. M. Willson |
| | John M. Beffel | E. A. Habeck |
| | S. A. Morton | Richard Foregger |

## THIRTEENTH DISTRICT

| | | |
|---|---|---|
| FOREST | E. F. Castaldo | B. S. Rathert |
| LANGLADE | F. H. Garbisch | C. E. Zellmer |
| ONEIDA–VILAS | Marvin Wright | I. E. Schiek, Sr. |
| PRICE–TAYLOR | J. D. Leahy | W. E. Niebauer |

## SECTIONS

| Section | Delegates | Alternates |
|---|---|---|
| GENERAL PRACTICE | G. E. Forkin | J. A. Grab |
| INTERNAL MEDICINE | R. N. Allin | R. A. Frisch |
| NEUROLOGY and PSYCHIATRY | Harry Tabachnick | E. Madison Paine |
| OBSTETRICS and GYNECOLOGY | A. A. Cantwell | W. O. Paulson |
| OPHTHALMOLOGY and OTOLARYNGOLOGY | E. J. Zeiss | Howard High |
| ORTHOPEDICS | D. W. McCormick | F. G. Gaenslen |
| PATHOLOGY | Gorton Ritchie | R. S. Haukohl |
| PEDIATRICS | F. J. Mellencamp | K. J. Winters |
| RADIOLOGY | W. T. Clark | R. L. Troup |
| SURGERY | J. M. Sullivan | M. G. Rice |

## *Election of Section Delegates for 1955*

**Sections will meet on Tuesday, October 5, at 4:30 p. m. in the following rooms in the Hotel Schroeder, to elect delegates for the 1955 House of Delegates.** ***(All on Fourth Floor)***

**GENERAL PRACTICE: Parlor A**
**INTERNAL MEDICINE: Parlor B**
**NEUROLOGY & PSYCHIATRY: Parlor C**
**OBSTETRICS & GYNECOLOGY: Parlor D**
**ORTHOPEDICS: Parlor E**
**PATHOLOGY: Parlor F**
**PEDIATRICS: Parlor G**
**RADIOLOGY: Parlor H**
**SURGERY: Parlor I**

**(Section on Ophthalmology and Otolaryngology Will Elect Delegate at Section Meeting, Wednesday, October 6.)**

# AUXILIARY CONVENTION PROGRAM 1954

## Monday, October 4

P.M.

4:00–6:00 Registration, Fifth Floor, Hotel Schroeder

6:30 Board of Directors' Dinner, English Room, Hotel Schroeder.

Those who attend: State Officers, State Chairmen, County Presidents and Presidents-Elect, Past State Presidents, and Honored Guests

(Dress, semiformal)

## Tuesday, October 5

A.M.

8:00 Registration, Fifth Floor, Hotel Schroeder The Hospitality Committee will welcome all doctors' wives who attend the meetings.

9:30 Formal opening of the Twenty-Sixth Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin, Pere Marquette Room, Hotel Schroeder

Mrs. C. R. Pearson, President, presiding

Invocation—Rev. Gordon Olston, Milwaukee

Pledge to Flag—Mrs. Henry Gramling, Milwaukee

Pledge of Loyalty to the Woman's Auxiliary to the American Medical Association—Mrs. E. S. Schmidt, Green Bay

Presentation of Convention Chairman, Mrs. H. C. Kappus, Kenosha

Presentation of President-Elect, Mrs. V. S. Falk, Edgerton

Address of Welcome—Mrs. L. H. Lokvam, Kenosha

Response—Mrs. T. L. Harrington, Milwaukee

Roll Call—Mrs. H. H. Fechtner, Wausau

Minutes of the Twenty-Fifth Meeting—Mrs. H. H. Fechtner

Reports of Officers

President-Elect—Mrs. V. S. Falk

Vice-President—Mrs. H. H. Wright, Milwaukee

Recording Secretary—Mrs. H. H. Fechtner

Corresponding Secretary—Mrs. J. F. Moon, Baraboo

Treasurer—Mrs. C. M. Creswell, Kenosha (Including report of Auditor)

Parliamentarian—Mrs. M. A. Bailey, Fennimore

Reports of County Presidents of 1953–54—Ashland–Bayfield–Iron through Langlade (Time limit, 2 minutes)

Reports of State Chairmen (Time limit, 2 minutes)

Credentials and Registration—Mrs. J. B. Pearson, Kenosha

Reports of County Presidents—Manitowoc through Winnebago (Time limit, 2 minutes)

MRS. GEORGE TURNER
El Paso, Texas
President of the Woman's Auxiliary to the American Medical Association

P.M.

1:00 Luncheon, East Room, Hotel Schroeder. In Honor of Mrs. George Turner, El Paso, Texas, President of the Woman's Auxiliary to the American Medical Association, Past State Presidents, and Members of the Marinette County Auxiliary

Presentation of Certificate of Merit to the Woman's Auxiliary to the Marinette County Medical Society (first auxiliary organized)

Mrs. F. A. Nause, Sheboygan

Response—Mrs. J. V. May, Marinette

"Leadership in Community Health"—Mrs. George Turner

"Today's Health Today"—Mr. Robert Enlow, Chicago, Circulation Manager, *Today's Health*

. . . Time to shop and visit the exhibits of the State Medical Society at the Auditorium

P.M.

7:30 Auxiliary members are invited to attend the second session of the House of Delegates of the State Medical Society in the Crystal Ballroom, Hotel Schroeder

## Wednesday, October 6

A.M.

9:00 Registration, Fifth Floor, Hotel Schroeder

9:30 General session, East Room, Hotel Schroeder

Mrs. C. R. Pearson, President, presiding

In Memoriam—Mrs. A. W. Hammond, Beaver Dam

New Business, including revision of By-Laws

Presented by Mrs. J. S. Huebner, Fond du Lac, Chairman, Revisions Committee

Convention Announcements—Mrs. H. C. Kappus

Report of Nominating Committee

Election of Officers

Installation of Officers—Mrs. George Turner

Presentation of President's Pin—Mrs. J. S. Huebner

Inaugural Address—Mrs. V. S. Falk

Credentials and Registration (Final Report) Mrs. J. B. Pearson

11:00 Post-Convention Board Meeting, Parlor H, Fourth Floor, Hotel Schroeder

Mrs. V. S. Falk, President, presiding

P.M.

1:00 Luncheon and Style Show, Crystal Ballroom, Hotel Schroeder

In Honor of County Presidents of 1953–54 Mrs. V. S. Falk, President, presiding

. . . Time to shop and visit the exhibits of the State Medical Society at the Auditorium

5:30 Reception of the President of the State Medical Society of Wisconsin, East Room, Hotel Schroeder

6:45 Annual Dinner, State Medical Society of Wisconsin, Crystal Ballroom, Hotel Schroeder

MRS. C. R. PEARSON
Baraboo
President

# Officers and Chairmen 1953-1954

MRS. V. S. FALK
Edgerton
President-Elect

## Officers 1953-1954

President _____ Mrs. C. R. Pearson, Baraboo

President-Elect _____ Mrs. V. S. Falk, Edgerton

Vice-President ____ Mrs. H. H. Wright, Milwaukee

Recording Secretary _ Mrs. H. H. Fechtner, Wausau

Corresponding Secretary _ Mrs. J. F. Moon, Baraboo

Treasurer _____ Mrs. C. M. Creswell, Kenosha

Parliamentarian ____ Mrs. M. A. Bailey, Fennimore

Immediate Past-President _____ Mrs. M. J. Reuter, Milwaukee

Directors

Mrs. E. F. Cummings, Oshkosh

Mrs. C. H. Falstad, Eau Claire

Mrs. H. E. Kasten, Beloit

Mrs. R. S. Pelton, Markesan

Mrs. F. W. Reibold, Superior

Mrs. M. J. Reuter, Milwaukee

Mrs. C. E. Zellmer, Antigo

## Committee Chairmen

American Medical Education Foundation _____ Mrs. L. M. Simenstad, Osceola

Archives _____ Mrs. J. W. Macgregor, Portage

Bulletin ____ Mrs. E. M. Dessloch, Prairie du Chien

Civil Defense _____ Mrs. G. A. Behnke, Kaukauna

Convention _____ Mrs. H. C. Kappus, Kenosha

Editor, *The Badger Doctor's Wife* _____ Mrs. R. F. Collins, Madison

Finance _____ Mrs. F. D. Weeks, Ashland

Legislative _____ Mrs. N. A. Hill, Madison

Mental Health ____ Mrs. H. H. Wright, Milwaukee

Nominating ____ Mrs. R. E. Fitzgerald, Milwaukee

Nurse Recruitment _____ Mrs. S. H. Ambrose, Whitewater

Organization _____ Mrs. V. S. Falk, Edgerton

Program _____ Mrs. H. W. Christensen, Wausau

Public Relations ____ Mrs. J. R. Richter, La Crosse

Revisions _____ Mrs. J. S. Huebner, Fond du Lac

Today's Health ____ Mrs. R. T. Schmidt, Green Bay

# Dramamine's® Effect in Vertigo

*Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.*

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

*The site of Dramamine's action is probably in the labyrinthine structure.*

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP *8*:35 (Nov.) 1953.

# Society Proceedings

## Green

A combination golf match and dinner meeting was held by the Green County Medical Society on July 27. The meeting was at the Monroe Country Club, Monroe.

## Richland

Twelve members of the Richland County Medical Society met at the Park Hotel, Richland Center, on July 1. At this meeting, *Dr. Seymour Crepea* of the Allergy Department, University of Wisconsin, spoke on "Seasonal Pollinosis."

## Trempealeau–Jackson–Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met on July 27 at the La Crosse Country Club as guests of the Gundersen Clinic, La Crosse. Eight members and the staff of the Gundersen Clinic attended.

Scientific papers were presented by *Dr. Robert Rasmus*, who spoke on "Canicola Fever"; *Dr. Harry Burich*, who spoke on "Cancer of the Lung"; and *Dr. Thomas Rutter*, whose topic was "Subtotal Gastric Resection for Duodenal Ulcer."

## American College of Chest Physicians

The American College of Chest Physicians registered 1,150 physicians and guests at its twentieth annual meeting in San Francisco, California, June 17 to 20. This was the largest registration of any of the College meetings held on the west coast. *Dr. A. A Busse*, Jefferson, is governor of the College for Wisconsin.

# News Items and Personals

## Dr. Elizabeth Comstock Delegate for European Meeting

*Dr. Elizabeth Comstock*, Arcadia, was appointed by the American Medical Association as official observer at the meeting of the World Medical Society in Rome, Italy. She was also chosen by the A.M.A. as delegate to the Congress of the International Medical Women's Association, which will meet at Lake Garda, Italy. The meetings are scheduled from September 15 to 23 and from September 26 to October 1.

## Doctor Peterson Resumes Independence Practice

*Dr. D. R. Peterson*, formerly of Black River Falls, has resumed the practice of medicine and surgery at Independence. He had been compelled to give up his practice at Black River Falls for some months because of ill health but now is fully recovered.

## Dr. Walter Schatz Leaves for Service

*Dr. Walter R. Schatz*, Racine, reported the first part of August at Camp Kilmer, New Jersey, for assignment in the Army Medical Corps in Europe. He holds the rank of lieutenant colonel.

## Doctor Danaher Opens Own Practice

*Dr. Harry H. Danaher*, formerly associated with the Gosin Clinic, Green Bay, has opened a private office in the Minahan–McCormick Building in that city. A graduate of Marquette University School of Medicine in 1946, he interned at Milwaukee County Hospital before entering military service. From 1947 to 1949 he was head of the obstetrics and gynecology department for the Caribbean Theater of Operations at Trinidad, British West Indies, with the rank of captain. In 1949 he returned to Milwaukee County Hospital for a surgical residency and was an instructor in the Marquette Department of Surgery for three years before moving to Green Bay.

## Elroy Physician Has Kendall Office Hours

*Dr. William E. Curtis*, who practices at Elroy, also has office hours at Kendall. He is in Kendall on Tuesday mornings and on Wednesday and Friday evenings.

## Dr. Richard Davis Opens Office

*Dr. Richard R. Davis*, who has been associated with the New Richmond Clinic for the past two and one-half years, has opened his own office. The office is located at 137 East Third Street, New Richmond.

## Community Honors Doctor Huber

More than 100 business people, professional associates, summer home owners, and area residents of Minocqua honored *Dr. Gale W. Huber* of that community on July 21 at a testimonial dinner. Doctor

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*Medical Director*
JACK L. KINSEY, M.D.
HERBERT W. POWERS, M.D.
JOHN A. STEMPER, M.D.

ESTABLISHED 1899

Huber was presented with a pen and pencil desk set.

## Dr. N. S. Davis, Jr., Located at Manitowoc

*Dr. Nathan S. Davis, Jr.*, formerly of Sturgeon Bay, has affiliated with *Dr. N. C. Erdmann* in the practice of medicine at Manitowoc. Doctor Davis practiced in Door County for three years prior to serving with the Army Medical Corps in Korea. He was graduated from Harvard Medical College in 1947, interned at Wesley Memorial Hospital, Chicago, and had a residency in internal medicine at Providence Hospital, Seattle, Washington.

Doctor Davis is the fourth Nathan S. Davis in succession to enter the medical profession. His father currently practices in Chicago and is an associate professor of medicine at Northwestern University, Evanston.

## Neenah Physician Now in California

*Dr. Robin Smith*, formerly of Neenah, is now associated with the Tiholiz Medical Group at Northridge, California. He is in the practice of pediatrics.

## Mineral Point Honors Dr. H. D. Ludden

When *Dr. H. D. Ludden* returned to Mineral Point recently following an Alaskan trip, he learned of plans of his community to honor him on August 8. He commented that he was "a little embarrassed over the whole thing, especially since they gave me a big send-off when I tried to retire in 1947." He has never been successful in his attempt to retire, however, and will observe his fiftieth anniversary in the practice of medicine next June.

The occasion included a parade and program at Soldier's Memorial Park.

Doctor Ludden was graduated from Rush Medical College, Chicago, in 1905 and interned at St. Mary's Hospital, Milwaukee. He began his practice at Kaukauna in 1906 and within a few months settled in Mineral Point.

## Green Bay Doctors Honor Sister Gregoria

When Sister Gregoria, anesthetist at St. Vincent's Hospital, Green Bay, left for Germany on July 18, she carried with her a "purse" which was presented to her by the physicians associated with the hospital. Sister Gregoria is the oldest registered anesthetist in the nation. She is making a trip to her homeland after an absence of 65 years, and it was the hope of the physicians at the hospital that the collection would make her trip more enjoyable. The presentation was made by *Dr. G. B. Merline* of De Pere, president of the Brown–Kewaunee–Door County Medical Society.

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## THIRD AND TWELFTH DISTRICTS NEWS

### Dr. Robert G. Zach Joins Monroe Clinic

*Dr. Robert G. Zach*, a graduate of the Marquette University School of Medicine, has joined the staff of the Monroe Clinic in the specialty of radiology. Doctor Zach interned at Mercy Hospital, Oshkosh, and completed courses in radiation physics at Marquette University, where he was also a teaching assistant for three years. He secured his residency at Veterans Hospital, Wood; Milwaukee Hospital and Milwaukee Children's Hospital, Milwaukee; Billings Hospital, Chicago Lying-In Hospital, and Chicago Tumor Institute, all of Chicago. He recently completed a course in atomic medicine at the National Argonne Cancer Research Hospital, Chicago.

### University of Wisconsin Announces Promotions

The University of Wisconsin Medical School has announced the following promotions in its staff:

*Dr. William H. Dornette* has been promoted from instructor to assistant professor in the Department of Anesthesiology.

*Dr. Henry A. Peters* has been promoted from instructor to assistant professor in the Department of Neuropsychiatry.

*Dr. Anthony R. Curreri* has been promoted from associate professor to professor in the Department of Surgery, and similar promotions from associate professor to professor have been given to *Dr. Kenneth Lemmer* and *Dr. Herman W. Wirka.*

*Dr. Frederick A. Davis* has retired as chairman of the Subsection on Ophthalmology, and the status of emeritus professor of ophthalmology has been approved for him by the Board of Regents.

*Dr. Arthur L. Tatum* has retired as chairman of the Department of Pharmacology, and the status of emeritus professor has been approved for him by the Regents.

### Dr. C. D. Partridge Named Kiwanian of Year

*Dr. Carroll D. Partridge*, Cudahy, whose research resulted in Milwaukee's milk pasteurization regulations in 1918, has been named "Kiwanian of the Year" by the Cudahy Kiwanis Club.

Doctor Partridge, now retired, was honored at a Kiwanis Club dinner on September 9. Born in Bennington, Vermont, he studied at the University of

Vermont and Johns Hopkins University. He taught chemistry and bacteriology before he came to Cudahy in 1924.

## Doctor Peterman Attends Polio Meeting

*Dr. M. G. Peterman,* Milwaukee, attended the International Conference on Poliomyelitis in Rome from September 6 to 10. He was the representative of the American Academy of Pediatrics.

## Doctor Foregger Fellow of Royal Faculty

*Dr. Richard Foregger,* Milwaukee, has been elected to the Fellowship of the Faculty of Anesthetists of the Royal College of Surgeons of England. Doctor Foregger is associate professor and director of the Department of Anesthesiology at the Marquette University School of Medicine and attending anesthesiologist at St. Joseph's Hospital, Milwaukee.

## SOCIETY RECORDS

### New Members

E. F. McNichols, 4057 North Sherman Boulevard, Milwaukee.

T. F. Garland, 9220 West Burleigh, Milwaukee.

P. L. Miller, Veterans Administration Hospital, Wood.

Isabel V. Estrada, 1725 North Prospect Avenue, Milwaukee.

Morris Klein, 4402 West Roosevelt Drive, Milwaukee.

P. E. Carroll, 4231 North 44th Street, Milwaukee.

S. T. Sandell, Middle River Sanatorium, Hawthorne.

L. H. Trachtenberg, Veterans Administration Hospital, Wood.

J. H. Young,** Elkhorn.

### Changes of Address

J. W. Christofferson,* Great Lakes, Illinois, to 2310 Club Boulevard, Durham, North Carolina.

D. M. Gallaher, Jr., Appleton, to 214 West Grand Avenue, Wisconsin Rapids.

G. P. Nichols,* Colorado Springs, to Box 26, Fitzsimons Army Hospital, Denver, Colorado.

J. W. Terry,* Milwaukee, to Med. Det., 710 Tk. Bn., Fort Campbell, Kentucky.

A. C. Theiler, Princeton, to Kiel Clinic, Kiel.

P. J. Bartzen, Milwaukee, to Duluth Clinic, Duluth, Minnesota.

L. M. Gorenstein, Indianapolis, Indiana, to 5981 Cadillac Drive, Speedway, Indiana.

R. G. Zach, Milwaukee, to 2545 9th Street, Monroe.

P. D. Nelson,* El Toro, California, to U. S. Naval Medical School, Bethesda, Maryland.

Elaine K. Pedersen, Philadelphia, Pennsylvania, to Muirdale Sanatorium, Milwaukee.

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* Military Service.
**Reinstated Member.

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N. S. Davis, Jr., Seattle, Washington, to 104 North 8th Street, Manitowoc.

J. W. Cortner, Madison, to 4850 East Center, Tucson, Arizona.

L. P. Wolf, San Francisco, California, to 4921 North Ardmore, Milwaukee.

## DEATHS

**Dr. L. H. Baldwin,** Gillett physician, passed away on August 6 at the Rockwood Convalescent Home near Dyckesville. He was 87 years of age.

Born on January 2, 1867, in Chicago, he received his medical degree from Bennett Medical College in 1895 and interned at Cook County Hospital, Chicago. He first practiced in Chicago, then at Merrytown, Wisconsin. He arrived in Gillett 56 years ago and for over 50 years served the families of that community.

He was a former member of the Oconto County Medical Society, the State Medical Society, and the American Medical Association.

Surviving him are three sons and one daughter. His wife preceded him in death.

**Dr. Charles H. Meyst,** who practiced at the Veterans Hospital, Wood, until his retirement in 1946, died at the Veterans Hospital on July 17 at the age of 78 years.

Born in Minnesota on February 9, 1876, he was graduated from the Milwaukee Medical College in 1902. While stationed at San Antonio, he took special training in tuberculosis and joined the staff of the V.A. Hospital in 1920. He had also practiced for several years at Burlington.

He was a former member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, Clementine; two daughters, Mrs. Evelyn McNaughton of Cleveland, Ohio, and Frances, Milwaukee; and two sons, William of Milwaukee, and Gardner, Elm Grove.

**Dr. William Earl Kiley,** 58, Milwaukee physician for more than 30 years, died at Columbia Hospital, Milwaukee on July 21, following a short illness.

He was born in Byron, Illinois, on October 8, 1895; graduated from Rush Medical College, Chicago, in 1920; and interned at Michael Reese Hospital, Chicago. He was resident physician at Columbia Hospital.

During World War I, he was civilian consultant in surgery at the Milwaukee induction center, and he was a senior regimental medical officer of the Wisconsin National Guard for 12 years.

Surviving him are his widow, Mary Louise; two daughters, Mrs. Paul S. King, London, England, and Miss Sheila Kiley, Milwaukee; two sons, William L., Argonia, Kansas, and Timothy M., Memphis, Tennessee.

Doctor Kiley was a former member of the Medical

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**Dr. E. R. Murphy,** who practiced medicine in Stratford from 1930 until his retirement last November, died in Milwaukee on July 19.

He was born on June 24, 1876, in Milwaukee and received his medical degree from Milwaukee Medical College in 1903. He interned at Milwaukee County Hospital, and from 1904 to 1915 he practiced at Gordon. He spent a year in Alaska as medical missionary and served in the Medical Corps in France in World War I, advancing to the rank of major.

After his discharge, he practiced at Antigo and Stratford.

He is survived by his widow, Helen, and one sister, Miss Genevieve Murphy, Milwaukee.

He was a former member of the Langlade County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

**Dr. Allen L. Millard,** Marshfield physician, died on July 14. He was 53 years of age.

Doctor Millard was born in New London on December 1, 1900. He was graduated from Rush Medical College, Chicago, in 1928. He was associated with the Marshfield Clinic almost continuously since 1928 and specialized in obstetrics and pediatrics. In 1931 he established a private practice in Appleton but returned to the Marshfield Clinic staff in April 1933.

Doctor Millard served as a major in the Reserve Officers Corps before World War II and was called to active duty in January 1941. He was discharged in September 1945 with the rank of lieutenant colonel.

He was a member of the Wood County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was also a member of the Wisconsin Heart Association.

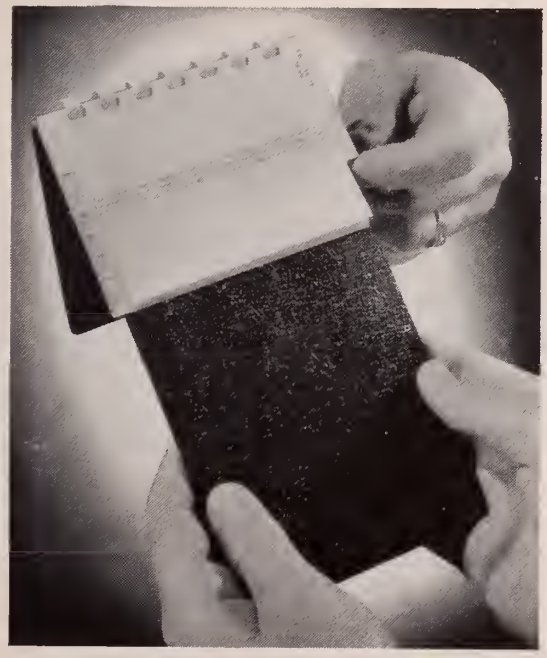
Surviving are his widow; two daughters, Margaret Ann and Emma Jane, Marshfield; and a son, Allen, Jr., Madison.

**Dr. Loran W. Beebe,** Superior physician, died in a local hospital on July 14 at the age of 89 years.

Doctor Beebe was born on a farm near Flint, Michigan, on March 7, 1865. He received his medical degree from Rush Medical College, Chicago, in 1891 and returned to Superior to practice with his father, Dr. Casper V. Beebe.

He was a member of the Fifty Year Club of the State Medical Society and was made a life member of this Society in 1947. He was also a member of the Douglas County Medical Society and the American Medical Association.

He is survived by his son, Edwin P., Superior, and three sisters.

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Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

**Practical X-Ray Treatment.** By Arthur W. Erskine, M. D. Fourth edition. St. Paul and Minneapolis, The Bruce Publishing Company, 1953. Price $5.00.

The purpose and nature of this book can best be characterized by the opening paragraph taken from the introduction to its first edition: "It has seemed to me that there is need for a small book on x-ray therapy devoted entirely to the methods of an individual in which no attempt is made to consider the opinions of various writers or to reconcile their differences. I have set down, therefore, as simply and clearly as I can, the methods used by myself and my reasons for selecting them. No claim is made that they are the best methods. On the contrary, it is certain that many of them should be, and will be, modified and improved. They have been fairly satisfactory, however, and they at least have the advantage of being simple enough to be easily described and accurately followed."

The subject matter has been arranged under the following headings: History, Current, Apparatus, Protection; Measuring Instruments (indirect and direct); Factors Affecting Skin Dosage; Factors Affecting the Depth-Dose Percentage; Standard Technics; Scattering and Distribution—this contains 14 scattering and distribution tables; Determination of the Skin Dose; Effects of X-Rays on Tissue; Skin Diseases; Infections and Inflammations; Nonmalignant and Malignant Conditions. Special attention is given to transvaginal x-ray therapy, in which the author was so deeply interested. There is also a brief, one may say philosophical, chapter dealing with the cancer problem and the radiologist.

The book is dedicated to the author's devoted wife, Betsy, who, after her husband's untimely death on December 10, 1952, took up the work of checking printer's proofs as she had worked very closely with him in preparing the manuscript. It is most regrettable that the author was not permitted to see the book in its final form.—E.A.P.

**Peptic Ulcer. Pain Patterns, Diagnosis and Medical Treatment.** By Lucian A. Smith, M. D., M. S. in Medicine, F. A. C. P., assistant professor of medicine, Mayo Foundation, head of section, division of medicine, Mayo Clinic; and Andrew B. Rivers, M. A., M. D., M. S. in Medicine, F. A. C. P., late associate professor of medicine, Mayo Foundation, consultant, division of medicine, Mayo Clinic. New York, Appleton–Century–Crofts, Inc., 1953.

The purpose of this book is to present peptic ulcer as a medical problem. The book's greatest usefulness will be as a reference to the gastroenterologist and to the internist. Any physician or surgeon, however, confronted with the problem of abdominal pain will find it of value because of its new approach to pain patterns, not only of the various types of ulcers and their complications but also in the differential diagnosis of other pain-producing diseases. The authors have drawn upon their extensive experiences at the Mayo Clinic, with which they have correlated the recent advances in knowledge of ulcer from the current literature. Peptic ulcer is recognized primarily as a medical problem. Its precise diagnosis, therefore, is necessary for adequate treatment to effect healing. Pain, as the chief symptom of ulcer, must be thoroughly understood. The anatomy of abdominal pain, both visceral and somatic, is of primary importance. Analysis of pain patterns and the diagnosis of ulcer, the type of ulcer, its complications, and related diseases represent the most valuable contributions. Special effort has been made to aid in the recognition of complications, especially those of chronically perforating ulcers.

An excellent chapter deals with pathologic anatomy. Here a profusion of gross and microscopic reproductions is used to advantage. The different types of ulcers, with their varying manifestations, are brought into focus by means of illustrious case histories and diagrams of pain patterns. Etiologic factors have received ample consideration. Other chapters deal with diagnostic laboratory aids, symptoms and diagnosis of ulcer as it occurs at different

sites, postoperative ulcer, and other postoperative complications. Hemorrhage, both as a complication and in conjunction with diseases of the blood, is covered in detail. In the chapter on obstruction, the disturbances of body chemistry are brought into focus. The chapter on roentgenologic diagnosis is contributed by C. A. Wood, whose many reproductions of x-ray films are most helpful. The medical treatment of peptic ulcer and its complications is considered in great detail in several chapters. The emphasis on the necessity of long-range management to prevent recurrences is illuminating in pointing out the failure of acute treatment for chronic disease.

No other book on peptic ulcer is quite like this one. The authors, in recognizing peptic ulcer as a medical disease, have emphasized the need for detailed study and specific diagnosis of the different types of ulcers and their complications. Only by thorough study can the uncomplicated ulcer be evaluated for medical management and the complications recognized for surgical referral.—K.L.P.

**Clinical Obstetrics.** By members of the staff of the Pennsylvania Hospital. Edited by Clifford B. Lull, M. D., late director, division of obstetrics and gynecology, Pennsylvania Hospital; and Robert A. Kimbrough, M. D., director of the division of obstetrics and gynecology, Pennsylvania Hospital, professor of gynecology and obstetrics, Graduate School of Medicine, University of Pennsylvania, gynecologist to the Graduate Hospital. Philadelphia, London, Montreal, J. B. Lippincott Company, 1953. Price $10.00.

This volume is a record of the current methods of obstetric care at the Pennsylvania Hospital. It includes an extensive survey of new research. There is a 90-page section on nutrition and the deficiencies of nutrition in pregnancy. Also included are an outline of obstetric nursing practices, a chapter on maternal and neonatal mortality, and a discussion of legal aspects of obstetrics.

However, the greatest part of this book is directed to the practical knowledge which students in clinical clerkships and the practitioner require for the management of maternity cases. There is a detailed presentation of the common laboratory procedures used in obstetrics, with interpretation of these procedures.

The chapters on dystocia and the complications of obstetrics are well handled. There is, also, an excellent chapter on the management of the normal infant in the neonatal period.

This is a comprehensive, practical work on clinical obstetrics which can be recommended to all students and practitioners of obstetrics.—M.J.T.

**The Medical Clinics of North America.** Boston Number. Philadelphia and London, W. B. Saunders Company, 1953.

This volume presents a symposium on specific methods of treatment, including articles on a num-

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ber of specialties. There is something for almost everyone, and it is difficult for the reviewer to understand what guided the selection of the material. However, if the reader is looking for the review type of article, he may find it very satisfactorily presented here.—E.C.A.

**Psychotic and Neurotic Illnesses in Twins.** Medical Research Council Special Report Series No. 278. By Eliot Slater, with the assistance of James Shields. London, Her Majesty's Stationery Office, 1953. Price $4.75.

This monograph is a report derived from case studies and family investigations of nearly three hundred twins who were suffering from psychiatric illnesses and treated in London hospitals. Part One of this volume reviews previous reports on investigations on twins in psychiatry and offers a detailed description of the methodology and results obtained in the present investigation. The second part of the volume is a compilation of the numerous case histories of the subjects studied in this investigation.

In general, the results of this study confirm previous studies regarding the importance of genetic factors in psychotic reactions. This same relationship was not demonstrated with clarity in the "psychopathic and neurotic states."

This monograph is well written. The study has been well conceived and conducted. The data presented support the conclusions of the author. Students of psychiatry, anthropologists, sociologists, and those interested in eugenics would find this volume to be interesting and informative.—T.H.L.

**May's Manual of the Diseases of the Eye.** For students and general practitioners. Revised and edited by Charles A. Perera, M. D., associate clinical professor, College of Physicians and Surgeons, Columbia University, New York, attending ophthalmologist, Presbyterian Hospital, New York. Twenty-first edition. Baltimore, Williams & Wilkins Company, 1953. Price $6.00.

This new edition continues to be the same excellent text for the student and general practitioner. Doctor Perera has revised and modernized the book wherever necessary, particularly in those sections dealing with pharmacology and therapeutics. The discussion of the use of the newer antibiotics and cortisone is now included. The section on motor anomalies has not yet caught up to modern thinking, however. The text continues to present ophthalmic surgery in rather too much detail for a work of this scope and purpose; and if surgery is going to be included, it should be brought in line with more modern technic.

This work remains one of the very best ophthalmology texts, as it has been for about 53 years.—F.J.D.

**Microbiology and Pathology.** By Charles F. Carter, B. S., M. D., Director, Carter's Clinical Laboratory, Dallas; and Alice L. Smith, A. B., M. D., Instructor


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in Microbiology and Pathology, Parkland Hospital School of Nursing, Dallas. Fifth edition. St. Louis, The C. V. Mosby Company, 1953. Price $5.50.

This is the fifth edition of a book which, according to the first edition preface, was an outgrowth of *Bacteriology for Nurses*, a book written by the first author in 1928. The first 463 pages deal with microbiological aspects; and in these pages there is discussed, in an elementary manner, the role in disease processes played by bacteria, fungi, yeast, Rickettsiae, viruses, and protozoa. There is also a brief consideration of roundworms and flatworms. While the book is primarily concerned with disease processes and related considerations, some attempt is made to indicate the useful roles of microbes. At the ends of most of the chapters, there are questions relating to the material presented. There is also a list of references at the ends of the chapters; and, in general, these references include other textbooks or review articles, although there are some references to original articles.

The last 320 pages are devoted to pathology, and this treatment is also presented in a similar sketchy manner. However, the treatment of this subject probably gives considerably more than is covered generally in most training courses for nurses.

There is included a glossary which should prove helpful to the beginning student.—G.W.

**Hospital Staff Appointments of Physicians in New York City.** Hospital Council of Greater New York, New York, The Macmillan Company, 1951. Price $3.25.

This book is an effort to present data concerning the well-known problem arising out of physician distribution in the metropolitan areas.

Specifically, it deals with the distribution of physician appointments on hospital staffs. There is the very telling observation that there are not sufficient hospital appointments open to general practitioners. The need for the staff member to use his hospital appointment not only to provide care for his private patient, but also to assist the hospitals in caring for the indigent patients, is presented. A ratio of 0.9 beds per physician appointment on general ward service and 0.6 beds per physician appointment on private services is worked out as an ideal situation.

An added item is the discussion of the need for appointments for Negro physicians as an aid to ward practice and teaching.—H.M.C.

**The Conception of Disease, Its History, Its Versions and Its Nature.** By Walther Riese, M. D., staff member of the Medical College of Virginia, Department of Mental Hygiene and Hospitals of the Commonwealth of Virginia, Richmond Professional Institute, College of William and Mary, Washington School of Psychiatry. New York, Philosophical Library, 1953. Price $3.75.

In a series of sometimes loosely connected short essays, the learned author examines about 14 possible conceptions of disease (the metaphysic, cosmological, etiologic, social, biographic, etc.). Although the author uses a great amount of historical material, this is not an orderly history of disease concepts, but a philosophical analysis.

The book will be welcome to all physicians interested in the philosophical aspects of medicine. It is not easy reading but is full of interesting material and penetrating ideas.—E.H.A.

**The Nursing Mother.** A Guide to Successful Breast Feeding. By Frank Howard Richardson, M. D., F. A. C. P., F. A. A. P. New York, Prentice–Hall, Inc., 1953. Price $2.95.

Without doubt, instruction to read Richardson's *The Nursing Mother* as part of the routine care practiced by physicians would lead to a great increase in the current incidence of breast feeding. Perusal of the book by physicians, too, will enhance the conviction of those who favor the natural feeding of babies and cause at least a wavering in the attitude of the skeptics. Instructors of public agency classes in the education of prospective mothers and nursery nurses will be delighted with it.

All aspects of breast feeding are well covered by the contents of the book. Proof of the physical and emotional advantages of breast feeding and of the ability of the majority of women to successfully nurse their babies is offered. Of special value and interest are the discussions concerned with: 1. the anatomy and physiology of the mammary glands, 2. the mechanics and technic of the emptying of the breast by the baby and by artificial methods, and 3. the prevention and management of "engorgement" of the breasts in the early postpartum period.

Other chapters include material on the role of the father in the care of the infant, rooming in, additions to the diet of the nursing baby, and natural childbirth. Scattered throughout at appropriate sites and at the end of the text are comprehensive lists of questions and answers for ready reference.—J.E.G.

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# FILM REVIEW

## "EXAMINING THE WELL CHILD"

This film is an excellent portrayal of a health examination of the well child and should be of interest to medical groups. It is a 16 mm. sound motion picture in full color. The film was produced by the Oklahoma State Department of Health in collaboration with the Oklahoma State Medical Association.

"Examining The Well Child" stresses to the medical profession the importance of the periodic examination of the child without apparent illness. The story is told from the standpoint of a doctor detailing the methods which he has found effective in his own practice. He reminds fellow physicians that the role of the doctor is that of teacher as well as diagnostician and impresses upon the audience the value of determining and correcting underlying causes of deviations from normal whenever possible.

In one of the cases, a simple, straightforward talk with an over-protective mother brings to light the reason for her attitude and, by the same means, the doctor is able to offer assurance.

In summary, the physician recognizes the responsibility of his profession in the prevention of illness and offers as his opinion that continuing care and periodic re-examination is the key to the healthy child.

The film was reviewed by the School Health Division of the State Medical Society and is recommended for showing to medical groups. It may be obtained free of charge from the film library of the State Board of Health in Madison.

E. H. Pawsat, M. D., *Chairman*
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# The Use of Intravenous ACTH in Status Asthmaticus

By EVERETT H. JOHNSON, M. D.
Turlock, California *

## Introduction

STATUS asthmaticus is a medical emergency that must be met with definitive therapy. At least 2,000 deaths directly attributable to bronchial asthma in the United States each year testify to its seriousness. It is true that the mortality rate from asthma has fallen in the past 20 years, but this is for the older patients. In those between the ages of 15 and 24, there has been an actual increase in deaths.[1]

Treatment of status asthmaticus has consisted of many combinations of bronchodilators, oxygen, parenteral fluids, expectorants, and sedatives. With the introduction of steroids, the concept of the general adaptation syndrome and alarm reaction,[2] the discovery of the decrease in circulating eosinophils,[3] and the inhibition of the antigen-antibody relationship after ACTH administration, it soon became apparent that an important group of drugs had been found.

At first, glowing articles appeared in the literature;[4-7] but, as time passed, reports of failures, refractoriness, and relapses appeared, thus giving the steroids less repute and the physicians who used them a feeling of insecurity.

We have obtained good results with steroids in patients in status asthmaticus who have not responded to other forms of treatment. Our experience is similar to that of Johnson,[5] who reported that, in addition to the immediate benefits, there is the added advantage that the individual appears to respond much more readily to the ordinary measures when a subsequent relapse does occur. This in itself is gratifying because before the days of steroids there was little that could be done when patients became "drug-fast" to the sympathomimetics. It is our belief, however, that steroids have no place in the long-term control of asthmatics, in some severe attacks of asthma, or in those patients in whom the usual measures have proved effective.

Treatment at University Hospitals, Madison, is based on the experimental work of E. S. Gordon.[8,9] It was first determined that ACTH given intramuscularly produced a transitory increase in the urinary excretion of 11-oxysteroids and 17-ketosteroids and a decrease in the circulating eosinophils. When ACTH was given slowly by intravenous drip, however, the increased excretion of steroids was more sustained. Even more important, the response was obtained on extremely small doses of ACTH, in the order of 0.5 mg. ACTH in one liter of fluid given over an eight-hour period. Further, as stated by E. C. Kendall,[10] a unit of ACTH can result in X to 1000 X stimulation of the adrenal cortex. Thus, the important factor is not the dosage of the drug but the length of time it remains in the circulating blood.

This present study concerns the results obtained in 14 patients (4 women and 10 men) treated with steroids who were admitted to the University Hospitals between February 1, 1951, and September 1, 1953. During that period, 407 patients with bronchial asthma were admitted, but only 14 were resistant to the usual measures of therapy prior to admission as well as refractory to our treatment for 48 hours or longer.

The dosage and method of administration varied considerably at first, depending on the circumstances; but generally the first day's therapy consisted of 25 mg. of ACTH in 1,000 cc. of 5 per cent glucose in distilled water given by intravenous infusion at a rate of 20 to 30 drops per minute. The administration was timed to last at least eight hours. Subsequently, 5 to 10 mg. of ACTH in the same diluent was administered for two or three successive days. Then cortisone in

* Formerly of Madison, Wisconsin.

TABLE 1

| Patient and Date | Age and Sex | Duration of Symptoms Prior to Treatment | Type of Asthma and Complications | Immediate Results Following Treatment with ACTH | Follow-up Information |
|---|---|---|---|---|---|
| H. D. August, 1951 | 50 F | 9 months | Intrinsic. Severe functional overlay. Emphysema | Moderate improvement in 8 hours. More definite improvement second day. Asymptomatic for rest of hospital stay | Wheezing commenced 1 month after discharge and has persisted to date during periods of stress, requiring steroid therapy. Complications—osteoporosis. |
| F. V. February, 1951 | 66 M | 3 to 4 years. Especially severe past 3 months | Originally extrinsic, now intrinsic. Emphysema | Marked improvement in 12 hours | Improvement continued for 3 months. Return of mild symptoms prompted a desensitization program. No follow-up |
| I. L. April, 1951 | 57 F | Severe symptoms past 3 years | Intrinsic chronic bronchitis. ASHD with low-salt syndrome before ACTH | Very definite improvement in 12 hours. No need for further symptomatic treatment after 24 hours | No follow-up |
| C. A. August, 1951 | 64 M | 2 years. Marked symptoms, 8 months | Intrinsic. Sinusitis. Emphysema. | Marked improvement in 24 hours and remained so throughout remainder of hospital stay | No follow-up |
| W. K. December, 1951 | 65 M | 8 months | Intrinsic. Sinusitis. Emphysema. | Slow, but definite improvement in 48 hours | No follow-up |
| F. L. June, 1952 | 46 M | 3½ years. Severe symptoms, 8 months | Intrinsic. Sinusitis. Severe functional overlay. | Minimal results in 48 hours as long as needle was in place. Immediate return of symptoms on discontinuation of drug. Considered a failure. | No follow-up |
| R. S. July, 1952 | 44 F | 19 years. Severe, 7 months | Extrinsic. | Marked improvement in 3 hours. Only other medication during remaining stay—KI | Seen in outpatient department 2 months later. She needed only occasional medication. Desensitization program started. |
| R. L. December, 1952 | 47 M | 9 months | Intrinsic. Nasal polyps—sinusitis | Improvement in 24 hours. Also had nasal and sinus surgery | No follow-up |
| J. G. March, 1953 | 65 M | 7 months | Intrinsic. Sinusitis. | In 8 hours $O_2$ stopped. Remainder of hospitalization uneventful | Admitted 1 month later following respiratory infection. ACTH used again with striking results. 2 months' progress good |
| W. V. March, 1953 | 46 M | Many years. Severe, 6 months | Extrinsic early, now intrinsic. Pulmonary fibrosis. Emphysema | Definite improvement in 12 hours. Patient very fatigued when treatment started | No follow-up |
| L. O. April, 1953 | 53 F | 2 years. Very severe, 3 weeks | Intrinsic. Rheumatoid arthritis. Periapical abscess | Marked improvement in 12 hours. Patient very fatigued when treatment started | No follow-up |
| L. K. June, 1953 | 74 M | 3 years | Intrinsic. Pansinusitis. Zenker's diverticulum. | Patient developed symptoms after operation in this hospital for the Zenker's diverticulum. Not controlled with adrenalin, etc., so ACTH used with definite benefits in 18 hours | Excellent indication for ACTH. No delay in healing and postoperative course otherwise uneventful |
| M. B June, 1953 | 37 M | 4 years. Severe, 6 weeks | Extrinsic and intrinsic. Emphysema. Sinusitis. Severe functional overlay. | Improvement in 24 hours. Associated euphoria | Symptoms returned and patient readmitted in 1 week. Less striking results the second time. 3 subsequent admissions. Very poor home situation (see text). |
| A. B. August, 1953 | 19 M | Since infancy | Extrinsic and intrinsic. Pulmonary fibrosis. Bronchiectasis. Emphysema. Eczema. Functional overlay. Spontaneous pneumothorax. | Improvement in 24 hours but symptoms returned so that ACTH was given daily for 21 days. Severely incapacitated by emphysema. | Patient transferred to local county hospital for long-term inpatient care. |

oral dosage of 200 to 300 mg. was given in four to six divided doses the first day, with daily reductions for a period of five to seven days.

A history of previous psychiatric disturbance, peptic ulcer, or tuberculosis precluded the use of the steroids. Likewise, during treatment careful attention was paid to weight gain, blood sugar and nonprotein nitrogen determinations, and adherence to a low-sodium diet. The wide-spectrum antibiotics were continued during therapy, as were an occasional bedtime sedative and aminophylline suppository.

The youngest patient was 19 years of age, and eight patients were over 50. Four had developed asthma during the preceding year, and seven within 1 to 5 years; and the re-

maining three had had symptoms for more than 5 years. Only one was considered to have extrinsic asthma alone; the rest had intrinsic asthma or a combination of the two. Complications and associated conditions included emphysema, pulmonary fibrosis, bronchiectasis, rheumatoid arthritis, severe psychosomatic overlay, arteriosclerotic heart disease, and chronic sinusitis.

Table 1 lists the patients; their age; sex; type of asthma, with secondary changes, complications, and results. It can be seen that the length of time between administration of the drug and the improvement was, in most instances, short. Within 12 hours after the infusion was started, 7 of the 14 stated that breathing was easier; and objective findings included a slower pulse and fewer expiratory rales, with obvious decrease in dyspnea. Five patients obtained benefit in 24 hours, one patient in 48 hours; one patient had no sustained objective or subjective improvement. This last patient was a 46-year-old white male who had had asthma for three and one-half years, with severe symptoms for eight months. He was extremely tense and insecure. As long as the needle was in place and the solution was running, there was no wheezing; but as soon as the infusion was discontinued, the patient complained bitterly of dyspnea, and wheezing reappeared.

Initially, our major concern was with relief of the status asthmaticus; but, as soon as the initial advantage was gained, the appropriate diagnostic studies, surgical procedures (polypectomy, antral windows, etc.), and allergy studies were carried out. The allergy studies, other than the history, were not done until the cortisone was discontinued.

Important lessons were learned from two patients in particular. A 37-year-old white male, M.B., was admitted to the hospital on June 14, 1953. He had been a known asthmatic patient for four years and had been in this hospital on three previous occasions. Previous studies had demonstrated sensitization to house dust, Alternaria, and feathers. Desensitization had been recommended, but no long-term program was followed. The patient developed status asthmaticus for the first time six weeks prior to admission and was treated at a local hospital for two weeks prior to entry without definite alleviation of symptoms. He had been given oral cortisone, 25 mg. four times a day, for several days; and, while on this medication, he attempted suicide without success, shortly after an argument with his wife.

On admission, the respiratory rate was 32 per minute; temperature, 101 F.; and pulse rate, 136 per minute. The patient was perspiring, grunting, and in an obviously critical condition. Examination of the chest revealed a definite increase in the anteroposterior diameter, with very little excursion, low diaphragms, hyperresonance of the lung fields, and prolongation of the expiratory phase. Expiratory rales were present. He had recent lacerations on the wrists.

Only minimal benefit was obtained with intravenous aminophylline, intramuscular adrenalin, oral oxytetracyclene, intrapharyngeal oxygen, and parenteral fluids. Sputum studies demonstrated a mixed flora. We were hesitant to use steroids because of the previous psychotic episode; but the patient's condition deteriorated so that on June 18, 1953, he was given 5 mg. of ACTH in 500 cc. of 5 per cent glucose in distilled water over an eight-hour period, and within 24 hours there was definite improvement. ACTH was given for three days, and then cortisone was initiated and used in decreasing doses and stopped on June 28, 1953. He continued to improve, and the only medication needed was nightly sedation. He was euphoric, but no other personality derangement appeared.

After leaving the hospital he took oxytetracyclene and was urged to receive desensitization. Symptoms recurred, and he was admitted to the hospital a week later with acute dyspnea but not in true status asthmaticus. Steroids again were used, but the results were not as striking. He has subsequently been admitted on three occasions, and each time there has been a period of emotional stress prior to admission.

This patient had an excellent initial response to intravenous ACTH, but with no lasting benefit, and then less striking results with subsequent usage.

The second patient, J.G., a 65-year-old male, was admitted on March 10, 1953. His asthma began suddenly 7 months previously, following a respiratory infection. He had been in status asthmaticus for four days prior to admission. He remained so after aminophylline, Seconal, adrenalin, ephedrin, and potassium iodide had been tried. He was given 25 mg. of ACTH in a liter of 5 per cent glucose in distilled water the first day and

5 mg. of ACTH each of the next two days, with subsequent shift to cortisone. Within eight hours there was marked relief of symptoms; and he was discharged on March 22, 1953, as asymptomatic. He did well until April 15, 1953, when he developed a respiratory infection and was readmitted three days later in status asthmaticus. The above regimen was again used after no success with the usual treatment, and the response was just as gratifying. He was seen in the outpatient clinic two months later, and he had been doing very well with only occasional use of the sympathomimetics.

This patient demonstrates a more favorable response, and in this case it is also suggested that the "drug-fastness" to the sympathomimetics was removed by the ACTH.

### Summary

Four hundred and seven patients with bronchial asthma were admitted to the University Hospitals over a 31-month period from February 1, 1951, to September 1, 1953. Of this number, 14 were refractory to the ordinary measures for the treatment of status asthmaticus. In these, intravenous ACTH was given by slow drip for 2 to 3 days, changing to cortisone for 5 to 7 days only. Initially, 7 of the 14 obtained benefit within 12 hours, 5 within 24 hours, and one in 48 hours; one patient derived little or no benefit. Two of the patients received ACTH again with decreased effectiveness, and two patients had repeated administration with a satisfactory response. All of the patients had the usual diagnostic procedures, desensitizations, and any surgical procedure deemed necessary.

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331 East Main Street.

The author wishes to express his appreciation to William S. Middleton, M.D., for his guidance and help in the preparation of this report.

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## EXHIBIT SPACE AVAILABLE AT WISCONSIN ACADEMY OF GENERAL PRACTICE ASSEMBLY

The Wisconsin Academy of General Practice has announced that it will accept requests from physicians and surgeons wishing to present scientific exhibits at the Academy's Sixth Annual Scientific Assembly, November 30 to December 1 at the Milwaukee Auditorium.

The Academy has reserved approximately ten booths for scientific displays and will furnish the booth, including tables, chairs, and electricity, free to a limited number of applicants. The booths are 10 feet by 10 feet. There will also be commercial exhibitors at the convention.

More than four hundred physicians are expected to attend the two full days of scientific talks, which feature speakers from Harvard and Chicago medical schools, the Mayo Clinic, and various other locations. Last year, three hundred physicians attended a two-day program at the smaller Hotel Schroeder.

Qualified physicians and surgeons interested in presenting scientific exhibits are requested to write for further information to Robert A. Dufour, Executive Secretary, Wisconsin Academy of General Practice, 758 North 27th Street, Milwaukee 8, Wisconsin.

# Should a Patient Be Told He Has Cancer?

By F. G. H. MALONEY, M. B., M. D., F. A. C. S., F. I. C. S.
Madison

SHOULD a patient be told he has cancer? Owen H. Wangensteen[1] of the University of Minnesota expressed his views on this subject in an editorial published in *Surgery*, and the following is a brief summary of his opinions. He believes that the most important person in an illness is the patient himself, a fact that is sometimes forgotten by the relatives and the physician, particularly when the patient has cancer. It is very difficult to fool a cancer patient very long, especially when the treatment is only palliative. The patient knows intuitively that the situation is grave when he progressively loses weight and becomes weaker. Then, the affected attitude of the physician and relatives is not difficult to solve. Very often the patient enters the game of hide and seek and strives to keep the relatives and the physician from learning that he knows he has a cancer. When that happens, the patient is denied the comfort and understanding companionship of his own family and is indeed a very unhappy person. Wangensteen ends his editorial with this sentence: "To fail to tell patients they have cancer is as archaic and outmoded as Victorianism."

Kelly and Friesen[2] published an article in *Surgery* on the query, "Do Cancer Patients Want To Be Told?" They interviewed 100 patients with known cancer in the outpatient department of the University of Minnesota. Eighty-nine per cent of the 100 cancer patients said they preferred knowing that they had cancer. Twenty-four of the patients in this cancer group were asked if the knowledge that they had cancer had in any way altered their routine of existence or style of living outside of changes made necessary by any physical disability. The answer was "no" in all cases. Many patients stated that they worried more about the unknown and felt they preferred to know they had cancer even if it was bad news because it removed the indefiniteness of the situation. Some were indignant that they had not been informed sooner.

Kelly and Friesen also made a fairly extensive review of the literature and found that Sachs[3] emphasized the psychological trauma to the patient on learning his situation. Piatt[4] believed that each patient should be handled according to his individual temperament and that, if the situation was hopeless, it was best not to inform the patient of his predicament except for very special reasons. Solomon[5] felt there was considerable psychic trauma in informing a patient that he had cancer. He urged that cancer education should stress what can be done for the cancer patient instead of morbidity statistics and the pessimistic views of what will happen to him. Cabot[6] believed that the patient should be told the truth and nothing but the truth. Lund[7] advocated, "as far as possible, do no harm" and pointed out that harm can be done by lying and also by telling the truth. Underwood[8] named fear, delay, and ignorance as the allies of cancer and stressed the importance of education in the fight against the disease.

In 1943, Seelig,[9] professor of clinical surgery at Washington University, was very emphatic in his stand against telling the patient he had cancer. He stated he had never told a patient that his disease was cancer except in those very few instances in which it was necessary to do so for special personal reasons or in order to shock the patient into a cooperative state of mind. Seelig believed that a cancer patient could never be certain of a cure and was always under suspense that the disease might strike again at some later date; and, for this reason, physicians should be willing to go to great lengths to avoid letting the patient know he has cancer. Seelig also stated that it is much harder on the doctor not to tell the patient. The moment the physician informs the cancer patient of his disease, the load is shifted from the mind of the physician to the mind and thoughts of the sick one. The physician then can go about his business unhampered by the constant guard to keep the patient from learning the truth.

An article by Fitts and Ravdin[10] of the University of Pennsylvania appeared recently in the *Journal of the American Medical Association*. The title was "What Philadelphia Physicians Tell Patients with Can-

cer." This survey included eight groups of physicians, including surgeons, internists, general practitioners, and the common specialties. The physicians as a whole group replied as follows:

| | |
|---|---|
| Always tell the patient | 3 per cent |
| Usually tell the patient | 28 per cent |
| | 31 per cent |
| Usually do not tell the patient | 57 per cent |
| Never tell the patient | 12 per cent |
| | 69 per cent |

When the replies were broken down into the various specialty groups, it was found that 31 per cent of the surgeons always or usually told the patient.

To determine what the surgeons of Wisconsin tell their cancer patients, a questionnaire was sent to each of the 118 active members of the Wisconsin Surgical Society. The questionnaire read as follows:

1. Do you tell the patient he has cancer?
2. Do you try to keep the patient from knowing he has cancer?
3. Do you tell the relatives?
4. Remarks.

One hundred eight of the 118 questionnaires were returned. In tabulating the results, it was difficult to confine the answers to a definite yes or no column. The remarks qualified the answers in 75 per cent of the replies. Some of the replies to question number one were as follows:

"Yes, no bad results in this program."

"Yes, I tell all my patients and I have not had one commit suicide and none have become unduly despondent."

"Yes, have found that patient cooperation and attitude as a rule are much better."

"Yes, I find that I get better cooperation with patients for further therapy and for follow-up if they know their situation."

"Yes, very few exceptions are not told."

"Yes, patients who know the truth about themselves are more satisfied with treatment given."

"Yes, unless the relatives object."

"Yes, but not when incurable."

"Yes, to get the patient to cooperate better."

"Usually, but not if the patient is mentally unstable."

"Usually, there is no definite pattern. Each case must be individualized, but usually tell the patient and do not try to prevent the patient from knowing."

"Usually, I don't think any hard and fast rule can be made. I believe there are many who should be told and there are occasionally some who should not be told, depending on the patient and the circumstances."

With these qualifications, 46 answered "yes" and 25 answered "usually"; the two groups together totaled 71. Roughly, then, 65 per cent of the Wisconsin surgeons usually tell the patient when cancer is the diagnosis.

There was another group of 20 replies, or 19 per cent, that stated "sometimes" the patients were told, but not as a rule. Some of the remarks on these cards were as follows:

"Only tell when necessary to secure cooperation."

"Depends on the patient."

"Only tell if necessary on account of business, etc."

"Rarely find a patient fitted mentally to tell."

The final group of 17 comprised 16 per cent of the replies. This group either did not tell or seldom told the patient and tried to keep him from knowing unless requested to do otherwise by the relatives.

The answers, then, from 108 of the 118 members of the Wisconsin Surgical Society, would indicate that 65 per cent of the trained surgeons of Wisconsin usually inform their patients when cancer is found. About 19 per cent are more conservative but do tell on some occasions, and 16 per cent still hold to the old belief that the patient should be kept from knowing he has cancer.

Over the past 50 years, our way of life has drastically changed; and one of the most obvious changes is probably our mode of travel. The horse of 50 years ago is a far cry from the jet plane of today. Our ideas, mode of practice, and knowledge of medicine have changed just as drastically as has our mode of travel. Some of us can remember back to the early 1900's when the textbook description of cancer of the stomach stressed cachexia, malnutrition, malaise, tumor mass, etc. In those days the diagnosis of cancer was usually made in the terminal stage at a time when cure was beyond hope. Then the diagnosis of cancer was a horrible thing, tantamount to a sentence of death. Cancer was looked upon as a sort of plague,

contagious, a disgrace to the family, and something that should be hushed up and kept secret. No wonder the family physician and relatives did not want the patient or anyone else to know that he had cancer. However, since the first World War, great strides have been made in diagnosis in general and in diagnosis of cancer in particular. In the post World War I period, the technic of x-ray diagnosis of the intestinal tract and other parts of the body was developed to a high degree of accuracy. In medical schools and hospitals, stress was placed on complete physical examinations combined with the use of the new x-ray and laboratory tests in making a more accurate diagnosis. Also, great advances were made in the use of x-ray and radium in the curative treatment of new growths, as well as in the palliative treatment to prolong life with reasonable comfort. Instruments with which practically every cavity of the body could be inspected were gradually developed. Improvements in anesthetics and methods of administering them permitted more extensive surgical procedures. The discovery of antibiotics, improvement in blood transfusion technics, and the Red Cross Blood Bank have made operative procedures safe so that now a diagnosis of cancer need not be the dread thing it was 30 or 40 years ago. The surgeon is now able to extend both his curative and palliative surgery to cancers which used to be considered inoperable. The operative mortality has gone down, the five-year surgical cure rate has gone up, and many patients with disseminated cancer are now living more comfortable and productive lives.

The American Cancer Society, the radio, newspapers, magazines, and life insurance companies have done a wonderful job of educating the public in medical knowledge and matters pertaining to health. Under the auspices of the American Cancer Society and with the cooperation of various medical societies, an intensive educational campaign has been going on for the past 25 years or more to acquaint the American citizen with the mysteries of cancer. The yearly cancer week, which the American Cancer Society has sponsored for years, has brought the subject of cancer out of the dark into the people's homes, with the result that many of them now have a yearly check-up examination for the possible presence of cancer. The average American adult knows that a lump in the breast or other part of the body should be investigated for possible cancer. He knows that any sore which does not heal or any abnormal passage of blood from any of the natural orifices of the body should be investigated to detect possible presence of cancer. He knows that early cancer which has not produced definite symptoms can be found only by periodic physical and x-ray examination. Many people have relatives and friends who have had cancer, some neglected with dire results and others operated or treated by x-ray or radium. The public knows cancer and is coming to our offices and asking for a so-called "cancer examination." Nowadays most people are medical-wise and know when they have had a proper examination. After the history and physical examination have been done and x-rays of the chest, stomach, colon, kidneys, or whatever other organs necessary have been requested, the patient wants to know why those x-rays are necessary. There is the first chance the doctor has to list the probabilities of the complaint and to include the possibility of "tumor." After the x-ray examination has been completed, the patient invariably wants to know the result and may often ask if he has cancer. If a cancer is present, how can one say "no"? If there is any possible doubt, the least one can say is that a tumor is present and that biopsy will be necessary to determine whether it is cancer or something else. If one denies the possibility of cancer at this point, he is slamming the door on a golden opportunity.

If the patient already knows there is a possibility that he might have cancer, it is easy to give complete confirmation or negation after the pathology examination. Then, no matter what the verdict, the patient looks upon the physician as a true friend. If, unfortunately, the verdict is cancer, the patient puts all his hope and trust in the physician for help. If the doctor lets him down by sidestepping the truth, how can he justify that faith?

In my opinion, a doctor has a great moral and legal responsibility to a patient who places himself under his care. In the first place, why does the patient consult a particular doctor? Why does he pick him out of the dozens of other doctors? Excluding the occasional transient, the patient consults a particular doctor because he trusts him. He may be his family doctor or he may have been recommended by a friend. Anyway, he goes to him because he trusts him and be-

lieves in him. If the doctor doesn't tell him the truth after completing a competent examination, can one believe that his trust in the doctor is well placed?

The usual excuse or reason for not telling the patient when a diagnosis of cancer has been made is that the relatives, the physician, or both, consider the shock too great for the patient to take. In other words, the patient is considered mentally incompetent to receive the diagnosis. If that is true, let us consider the morbidity and mortality of coronary occlusion. Coronary heart disease is common and is well known to the public of today. It strikes suddenly. If the individual is so fortunate as to survive the initial attack, he lives under the constant threat of another occlusion, maybe fatal. Yet, do the family and the doctor hesitate to tell him the truth? And, when told, does the patient go into some terrible mental collapse? No, he doesn't, because heart disease is common and people are familiar with it. Nowadays cancer has become well known to the public through education, and the blind fear of the word "cancer" has been dispelled. Fear is caused by lack of knowledge.

In the state of the Union report on "The Health of the Nation" by the 83rd Congress,[11] there is a very interesting and informative chapter on cancer. It has this to say. Evidence from many sources shows the value of the great national effort to control cancer. About one-fourth of patients with cancer today are being cured. Twice this number could be cured if early diagnosis and prompt adequate treatment could be achieved in all cases. As an illustration, only 20 per cent of cancer patients admitted to hospitals in Vermont in 1937 had localized disease and were considered candidates for curative treatment. Ten years later, the percentage of curable cancer patients had risen from 20 to 58 per cent. A report from the Mayo Clinic showed that the five-year survival in breast cancer jumped from 39 per cent to 62 per cent over a 30-year period. This experience has been duplicated in the Memorial Center for Cancer and Allied Diseases in New York. The cancer registry of Connecticut shows that five-year survivors increased from 22 per cent in 1929 to 33 per cent in 1941.

In conclusion, I believe that our concept of what the cancer patient should be told should be revised to take into consideration several factors:

1. The people of today are well informed as to the mysteries of cancer, and much of the fear and dread of the disease has been dispelled by well-planned cancer education.
2. Due to this education the people are requesting prophylactic "cancer" examinations which lead to earlier diagnosis and better prognosis.
3. More extensive curative and palliative operations are possible due to antibiotics, easily available blood transfusions, and better anesthetics.
4. The life expectancy for the early treated cancer patient is increasing steadily.
5. Palliative surgery, coupled with x-ray and radium therapy, is extending the life span of many people with incurable cancer.

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Quisling Clinic.

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## ERRATA

An error on the President's Page (p. 492) of the September issue of the Journal has been brought to our attention. The sentence beginning in the center of the fourth line, third paragraph, should have read: "It is just plain inevitable that when government takes over, individual responsibility toward oneself is minimized and many of our individual prerogatives are put in jeopardy."

# A Case of Ruptured Ectopic Pregnancy Coexisting with Twisted Ovarian Cyst

By J. D. ZERATSKY, M. D., and P. R. McCANNA, M. D.
Marinette

ECTOPIC pregnancy, extrauterine pregnancy or eccyesis is the existence of an embryo or fetus outside the uterine cavity. The classification as to location is: 1. tubal, 2. ovarian, 3. abdominal, 4. cervical. Tubal pregnancies by far outnumber the other types. One of the earliest recorded cases of tubal gestation was recorded by Riolanus[1] in 1604. The patient developed the classical symptoms of tubal rupture and died. An autopsy revealed that the right Fallopian tube contained a fetus, while the uterus appeared healthy and normal. More cases of similar nature were reported since that time; now they are commonplace. Robert Lawson Tait[2] in 1883 became the first to operate successfully for ruptured tubal pregnancy and established the operative technic for this condition.

Ovarian cysts become important clinically when they attain such size or occupy such position that they cause symptoms, and not infrequently do they possess a stalk or pedicle which undergoes torsion and requires surgical interference. Mathieu[3] considers twisted ovarian cyst one of the most common pathologic states to be distinguished from ectopic gestation. It is not uncommon for either condition to exist alone. Less common, however, but still very evident in the literature, are descriptions of the complication of a normal uterine pregnancy by ovarian cysts, either single or multiple.[4] Pescovitz and Noone[5] reported a torsion of ovarian cyst in a term pregnancy; it was removed surgically and proved gangrenous. Their patient delivered a normal male child three days after surgery.

We recently saw a patient who had a ruptured tubal pregnancy on one side and a cyst with torsion on the opposite side, a most unusual and rare combination.[6]

## Case Report

The patient, a 23-year-old white married woman, was seen for the first time on April 1, 1954. She had a normal menses on March 18, and it lasted five days. On March 29 she began to "spot" and continued to do so intermittently until she came to the office. She had occasional cramps, but they were not severe; she had no vomiting or diarrhea. This spotting, coupled with fatigue, was her main complaint. She had one child, a boy two years old, delivered after a normal pregnancy with no complications. Pelvic examination revealed no uterine enlargement, no palpable mass or tenderness at this time. The cervix was clean and firm; a chocolate-colored discharge exuded from the os. The blood pressure was 110/70, the hemoglobin, 15 Gm. The rest of the examination was negative. The patient was treated expectantly after a diagnosis of possible uterine or extrauterine pregnancy was made.

On April 6 at noon this patient was seen at home lying in bed with knees flexed and with acute severe generalized abdominal pain. She experienced this suddenly while standing combing her hair. The blood pressure and pulse were normal. The abdomen was soft but exquisitely tender in the pelvis, especially on the right side. There was no vaginal bleeding and no picture of shock. In view of her past history, we made a diagnosis of ruptured tubal pregnancy, probably on the right side, and advised a laparotomy. The patient was hospitalized, typed and cross-matched, and prepared for surgery that afternoon.

Under Pentothal anesthesia, a lower abdominal midline incision was made and the peritoneum opened. On exploring the pelvis, an ovarian cyst the size of an orange was found on the right side lying anterior to the broad ligament. This was on a pedicle and had twisted twice in a clockwise direction. The pedicle was ligated and the cyst excised. The right tube was normal, as was the uterus. On the left side, a tubal pregnancy was found near the fimbriated end of the Fallopian tube. Slight bleeding posterior to the broad ligament had occurred. The distal portion of the tube and the appendix were normal. This woman was up on the second

postoperative day and was discharged on April 13 after an uneventful recovery.

The ovary was enlarged to 8 cm. in greatest diameter by many multilocular cysts containing reddish fluid. The tube consisted of a bloody mass 5 by 1.5 cm., on the cut surface of which were seen chorionic villi and decidua.

### Comment

The symptoms which may lead to a diagnosis of ectopic gestation can be so confusing that the physician may well consider the possibility of this condition in any woman of childbearing age who complains of unilateral lower abdominal pain and menstrual irregularity of recent origin. Ovarian cyst with twisted pedicle may give rise to diagnostic confusion. The sudden severe pain with nausea and vomiting may occur in cases of both ectopic pregnancy and ovarian cyst. In the latter, the twisted pedicle is responsible for the symptoms. Either condition usually necessitates surgery.

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## PSYCHIATRY COURSE OFFERED BY ST. JOSEPH'S HOSPITAL, MILWAUKEE

The medical staff of St. Joseph's Hospital offers a course of ten weekly lectures entitled, "Emotional Problems Encountered in Everyday Medical Practice." Lectures will be given every Wednesday evening from 8 to 9:30 p.m., beginning on Wednesday, October 13, 1954, in the basement staff room of the hospital.

The course is designed for those physicians who see the earliest cases of emotional and behavior disorders, who must treat the majority of psychological problems in the community, and who are being called upon increasingly to preserve the mental health of the people. The objectives of the course are: 1. To introduce the doctor to broad patterns of human motivation and to the common causes and backgrounds of emotional disturbance; 2. To lead him to think in terms of the relation between emotional disturbance and illness; and 3. To teach easily understandable methods of therapy.

The course will consist of didactic lectures supplemented by slides and sound films. Each session will consist of a one-hour lecture followed by a thirty-minute question-and-answer period. There will be one session devoted to the demonstration of cases.

A distinguished faculty, with Dr. Chris Buscaglia as chairman, will discuss the following topics:

October 13—The Meaning and Diagnosis of a Psychoneurosis—Dr. John A. Stemper

October 20—Acute and Chronic Alcoholism and Addiction to Drugs—Dr. Paul J. Lawler

October 27—The Nature of Anxiety—Dr. Saul K. Pollack

November 3—Depressions—Dr. John A. Stemper

November 10—Psychosomatics—Dr. Samuel B. Black

November 17—Physician-Patient Relationships, Including Aspects of Long-Term Illness—Dr. Roland A. Jefferson

November 27—Demonstration of Cases to be Conducted at Milwaukee County Hospital for Mental Diseases—Dr. Michael Kasak

December 1—Panel Discussion—Dr. Francis J. Millen, Dr. Paul J. Lawler, Dr. Chris Buscaglia

December 8—Primitive vs. Contemporary Ways of Finding Happiness—Dr. William H. Studley

December 15—To be announced

The course is open to Wisconsin physicians. Credit for the American Academy of General Practitioners will be arranged.

The registration fee is $20. For further information, write Postgraduate Program, St. Joseph's Hospital, Milwaukee.

# Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

## "The Harmful Effects of Tobacco"[1]

There exists in the minds of many the opinion that the habit of smoking tobacco is potentially, if not actually, harmful to the individual concerned. Since the use of tobacco is a habit and not an addiction or a necessity, the effects of prolonged indulgence may be difficult to establish because an individual is likely to have been exposed to other circumstances that may have contributed, or even caused, the symptoms occasionally ascribed to the use of tobacco. Consequently, there has resulted a paucity of incontrovertible evidence that could satisfy a critical investigator; and, for this reason, recourse must be had to statistical evidences, with a comparison, as much as is possible, to a control series of subjects.

No one can doubt from even a cursory analysis of available evidences that, on a basis of population percentage, known cases of cancer of the lung have increased greatly in the last twenty years. This has been the period in which a very great increase in cigarette smoking has occurred, measured both in the total numbers of persons smoking and in the average number of cigarettes smoked per person per day. The great increase is predominantly in men. There is no doubt about the increase in cigarette smoking; and this increase, as just stated, pretty well parallels the notably increased percentage incidence of lung cancer. Furthermore, it has been found that the incidence of cancer of the lungs increases more or less proportionally to the number of cigarettes smoked per individual per day. At a conference, referred to by the title of these comments, Doctor Wynder stated that cancer of the lung accounts for one-fourth of all cancer deaths in males in this country.

While smoking cigarettes appears to be more dangerous (because of inhalation) than smoking of pipes or cigars, each of these latter two habits is associated with a significantly higher incidence of lung cancer than the incidence in nonsmokers.

Cancer of chimney sweepers has been long recognized, so it was but logical to try to determine whether or not the tars of tobacco applied to the backs of mice produced cancer. After application (three times a week) of tobacco tar, dissolved in acetone, for a period of two years, one-half of the animals had developed cancer of the skin. Acetone alone produced none. This experiment on mice proves that the irritant tars of tobacco applied throughout a sufficiently long period may produce cancer in these animals, but would it not have been more to the point had the investigators administered unwashed tobacco smoke to mice in such a way as to make them inhale the fumes? The investigators referred to above state that they ". . . do not believe that chronic irritation, *per se*, is carcinogenic," but that the carcinogen is a specific substance for which they now are searching.

If carcinogens are specific substances, as well they may be, they are evidently produced *in situ*, since either mechanical or chemical irritation may be carcinogenic. One referee at the conference stated, in effect, that he had never seen a case of thromboangiitis obliterans and cancer of the lung in one and the same patient, which indicates to him the probability of different causative agents in these two disease conditions.

It is obvious from the foregoing that cigarette smoking may be carcinogenic or harmful to some individuals, but which ones may be seriously susceptible cannot be foretold.—A. L. TATUM, M.D.

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# Mesenteric Vascular Occlusion

## Presentation of Six Cases, One Surviving Massive Resection of the Small Bowel*

By E. E. ECKSTAM, M. D., M. S., F. A. C. S., and G. R. BARRY, M. D.**
Monroe

FEW surgical emergencies are more difficult to diagnose and treat successfully than mesenteric vascular occlusion. Prompted by the occurrence of this condition in a patient who survived resection of nearly all of the small bowel, we prepared this report and included summaries of five other cases operated upon since the opening of St. Clare Hospital in 1938. These six cases have not been reported previously.

A comprehensive review of mesenteric vascular occlusion appears in several recent articles.[1-7] The incidence is one for every 5,000 or 10,000 hospital admissions,[6] and cases of arterial embolism and thrombosis slightly outnumber those of venous thrombosis. Embolism usually follows coronary heart disease or auricular fibrillation, whereas thrombosis usually follows abdominal infections and sometimes mechanical obstructions, trauma, and anemia.

The condition is usually found in a man about 60 years of age who has a sudden onset of moderately severe upper abdominal pain, with nausea and vomiting and perhaps diarrhea, and whose abdomen is tender and a little rigid. Later, his abdomen distends, becomes silent and more rigid. His temperature is only slightly elevated. He looks severely ill and is in shock that resists therapy. The white blood count is about 25,000, with about 90 per cent polymorphonuclear leukocytes, half of which are nonsegmented. X-rays of the abdomen show a bizarre pattern of semidistended loops of small bowel with fluid levels. The diagnosis will usually be missed; but, if the patient is not too ill, the true condition will be revealed at surgery.

As the incision is made, serosanguineous semifoul fluid exudes from the wound. The bowel is usually not greatly distended. The infarction may involve any part of the small bowel or all of it and may also include the right colon. During the first few hours of symptoms, because of reflex muscle spasm and subsequent muscle fatigue, segments of the bowel will vary in appearance and may be blanched, mottled, or blue.[3] Later, hemorrhagic infarction appears. The early stages may survive conservative therapy. However, the best hope for cure is resection of the entire involved segment, regardless of how extensive it may be.

Postoperatively, most patients will require gastric decompression; antibiotics; anticoagulants; cardiac therapy; fluid and electrolyte replacement; and, later, dietary measures. The remaining stomach, small bowel, and colon adapt remarkably well to carbohydrates and proteins but not to fats.[1, 8] The body weight is decreased to conserve caloric and protein requirements.

### Case Report

*Case No. 6—Mrs. A. Z.—No. 34-062:* A 63-year-old white female was first seen at the Monroe Clinic on January 6, 1954, with complaints of right upper quadrant pain and shortness of breath. Three to four years previously she had an attack of right upper quadrant pain diagnosed as gallbladder disease. On January 1, 1954, she had severe right upper quadrant pain. Her urine was dark, but no jaundice was noted. Bowel movements were black, presumably from oral iron therapy.

She had taken digitalis for one year because of dyspnea and recently had noted ankle edema and orthopnea. She probably had received large doses of digitoxin just previous to admission; this resulted in nausea and vomiting.

A right oophorectomy was performed 20 years ago. She said she had "pus in the kidneys" one year ago, insomnia, and frequent frontal headaches.

Her weight was 126 pounds; blood pressure, 120/76 mm. of mercury; temperature, 97.2 F.; pulse rate, 62 beats per minute. Her skin was slightly icteric, and the fundus ves-

* Read before the Wisconsin Surgical Society, May 1, 1954.

** From the Departments of Medicine and Surgery, The Monroe Clinic, Monroe, Wisconsin.

sels showed grade I arteriosclerotic changes. Fine, scattered rales were heard in both lung bases. The left border of the heart was at the mid-clavicular line. Slow auricular fibrillation without pulse deficit was noted. No murmurs were heard. The liver was moderately tender and could be felt two fingerbreadths below the right costal margin. Both lower quadrants were slightly tender. The patient had moderate edema of the ankles. The pelvic examination was unsatisfactory because of tenderness and obesity, and no gross abnormalities were found.

The laboratory reported 4,400,000 red blood cells and a hemoglobin of 14.4 Gm. per cent. The white blood cell count was 7,200, with 16 per cent nonsegmented, 40 per cent segmented polymorphonuclear leukocytes, and 44 per cent small lymphocytes. The icterus index was 18.1 units; alkaline phosphotase, 1.1 units, cephalin flocculation test, negative; and blood serology, negative. Voided urine contained four-plus albumin and one to two red blood cells and four to five white blood cells per high power field. The nonprotein nitrogen was 52 mg. per cent.

An electrocardiogram revealed auricular fibrillation, a ventricular rate of approximately 80 beats per minute, and signs of myocardial damage. A chest x-ray showed an increase in the transverse diameter of the heart, a tortuous aorta, and old pleural thickening at the right base.

Six days after admission, the nausea and edema subsided, the icterus index decreased to 10 units, and a catheterized urine specimen was normal. The irregularity of the pulse persisted. The gallbladder was found to be nonfunctioning.

About 8:00 a.m. on January 17, the patient became nauseated and complained of severe epigastric pain. She soon vomited bile and perspired freely. By midafternoon her pain was very severe, and 10 mg. of morphine sulfate gave only slight relief. The pain shifted to the lower abdomen and was crampv and sharp. Slight distention, guarding, and rebound tenderness were noted. Normal bowel sounds were heard. She vomited again, and her skin became pale and faintly yellow. At 8:00 p.m. she had a brown bowel movement. At 10:00 p.m., her abdomen became more distended and tender all over, especially in the right lower quadrant. Spasm was generalized but greater in the right lower quadrant, where rebound tenderness was referred. No mass was felt. Rectal and vaginal examinations revealed both lower abdominal quadrants to be equally tender. Flat and upright films of the abdomen showed occasional loops of gas-filled bowel, with fluid levels, and arteriosclerotic changes in the aorta. The white blood cell count was 20,200, with 50 per cent nonsegmented, 40 per cent segmented polymorphonuclear leukocytes, and 10 per cent lymphocytes. The red blood cell count was 4,150,000, and the hemoglobin was 14.3 Gm. per cent. Blood pressure was 130/80 mm. mercury, and the pulse rate was 100 beats per minute.

Preoperatively, the diagnosis was perforated appendix or perforated gallbladder.

At surgery, the greatly distended stomach was decompressed with a Levine tube via the nose. The gallbladder contained stones. The uterus and right adnexal structures were absent. Most of the small bowel was dusky blue, and little of it exhibited peristalsis. No arterial pulsations were felt in the base of the mesentery. Arterial pulsations were felt within a foot of the ligament of Trietz and within less than a foot of the ileocecal valve. The cut ends of the vessels in the mid-portion of the mesentery did not bleed. The involved bowel was removed, and the resection was extended well into the area of normal blood supply. An end-to-end anastomosis was done, using an inner row of continuous chromic catgut and an outer row of interrupted silk. The anastomosis admitted one finger. The mesentery was loosely closed with catgut, and the wound was closed.

The patient's condition during surgery was critical. The blood pressure fluctuated between 100/60 and 80/50 mm. of mercury. The pulse rate varied between 60 and 90 beats per minute and was irregular. She received 1,000 ml. of dextran and 1,000 ml. of five per cent glucose in water.

The section of bowel removed was 250 cm. long. The attached mesentery was pale and bloodless. The bowel was hemorrhagic, had a foul odor, and was irregularly discolored. Necrosis of the entire mucosa and congestion of the vessels were seen in the microscopic specimens. Many of the small vessels in the mesentery were empty. The pathologist concluded the thrombus or embolus was in the main superior mesenteric artery.

After the operation, the patient was given oxygen nasally, gastric decompression, 500 mg. of Aureomycin intravenously, 40 ml. of

TABLE 1

| Case | Date | Age | Sex | Pain | Location | Sudden | Nausea and Vomiting | Melena | Shock | Tenderness | Distention | Rigidity | White Blood Cell Count | Polys | X-Ray | Associated Conditions |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 15072 | 1948 | 58 | M | 4+ | RLQ | + | + | 0 | — | 2+ | | + — | 24,000 | 95% | — | A-S Heart Cholelithiasis Post CVA |
| 17830 | 1948 | 38 | F | 4+ | LUQ | + | + | + | + | + | + | + | 27,000 | 91% | + | Cholecystitis, 1 month post-partum |
| 23493 | 1950 | 67 | M | + | LOW | + | 0 | + | — | + | + | + — | 20,000 | 85% | + | Thrombophlebitis, legs, 1948 |
| 13728 | 1950 | 77 | M | 4+ | MID | + | 0 | 0 | — | 3+ | — | 3+ | 0 | 0 | 0 | Cholelithiasis |
| 28009 | 1951 | 71 | F | + | LLQ and EPIG. | — | + | + | — | 3+ | + | — | 24,000 | 80% | + | A-S Heart fibrillation |
| 34062 | 1954 | 63 | F | 3+ | EPIG | + | + | — | — | 3+ | 2+ | + | 20,000 | 90% | + | Fibrillation Cholelithiasis |

+ Present.
— Absent or No.
0. Not Recorded.

aqueous adrenal extract intravenously, caffeine sodium benzoate, penicillin and streptomycin intramuscularly. Her pulse decreased from 90 to 70 beats per minute, and her blood pressure returned from 80/60 mm. of mercury to normal in 36 hours. Demerol was used to control pain; 1 ml. of lipo-adrenal extract was used daily for two days; Aureomycin, 500 mg. intravenously daily for six days; penicillin, 400,000 units; and streptomycin, 0.5 Gm. every six hours for nine days. Digitoxin and diuretics were used as indicated.

The Levine tube was removed on the third postoperative day, and sips of water were given. On the fifth postoperative day, a postoperative gastric surgery type of diet was started; and on this day the patient had two soft-formed, brown stools. Her abdomen was moderately distended and remained so. A flat plate of the abdomen on the seventh postoperative day showed a greatly distended colon.

Dicumarol therapy (200 mg. the first day and 100 mg. daily thereafter) was started on the fifth postoperative day but had to be discontinued because of intestinal bleeding on the eleventh postoperative day, when a blood transfusion and 72 mg. of Vitamin K were given. Dicumarol therapy (100 mg. daily) was resumed on the fifteenth postoperative day but was stopped the next day, when more blood and Vitamin K were given to control intestinal bleeding. Additional blood was given on the twentieth postoperative day to bring the blood count up to normal. Five pints of blood were used during the patient's hospital stay. On the seventeenth postoperative day her stools were tarry in spite of the fact that she had only one foot of ileum left.

Solid foods were begun on the fifteenth postoperative day; but, because the patient was having 10 to 12 loose stools per day, antispasmodics were started. X-rays of her stomach and small bowel on the eighteenth postoperative day showed slight narrowing of the anastomosis with slight dilatation above. The barium was in the cecum in 1½ hours.

The patient was dismissed from the hospital on the twenty-seventh postoperative day. She had six to eight semi-soft, brown stools per day that did not float. A low fat, high carbohydrate, moderate protein diet; antispasmodics; and codeine compounds were prescribed. She has remained well and has maintained her weight at about 100 pounds, which is 80 per cent of her preoperative weight. Pancreatin, 2.4 Gm., pepsin, 2 Gm., and bile salts, 1.2 Gm. daily did not influence the type or quantity of stools.

### Summary of Cases

Among 56,372 hospital admissions since 1938, five other patients with proved mesenteric thrombosis have been seen. (Table 1) Four additional patients were considered to have this condition; but, since the diagnosis was not proved by surgery or by autopsy, they have been excluded from this review.

TABLE 1—(Continued)

| Case | Length of Bowel | Anti-coag-ulants | Resec-tion | Result | Preoperative Diagnosis |
|---|---|---|---|---|---|
| 15072 | "Several feet" ileum | — | — | Died PO 1 | Perforated appendix |
| 17830 | 3′ ileum | — | + | Died in surgery Pulmonary embolism | Probable mesenteric thrombosis |
| 23493 | 2′ ileum | + | + | Recovered (died in 3 weeks of progression) | Bowel obstruction |
| 13728 | 2½′ ileum | — | + | Recovered | Perforated ulcer |
| 28009 | 6′ jejunum | + | — | Died PO 2 | Perforated appendix or bowel |
| 34062 | 8½′ small bowel | + | + | Recovered | Perforated appendix or gallbladder |

Three of our six patients were males, and the average age was 62. Most had moderately severe pain in various parts of the abdomen. Slight nausea and vomiting were noted in four. All were moderately to severely tender. Most had some degree of rigidity when first seen, and all but one had a reasonably sudden onset. Slight distention was noted in four, and melena was noted in three. Shock was surprisingly absent, as evidenced by pulse and blood pressure readings. Four patients had associated cholelithiasis, and three had associated heart disease. The preoperative diagnosis was correct in only one case. Other preoperative diagnoses included perforated appendices, perforated gallbladders, and bowel obstructions.

Of the two not resected, both involved several feet of the jejunum or ileum; both patients died by the second postoperative day. Of the four resected, one died suddenly, presumably from a pulmonary embolus after three feet of ileum had been resected. Another patient had two feet of ileum resected and, upon re-entry to the hospital three weeks later, died of recurrent mesenteric vascular occlusion. Another died of a coronary occlusion one and one-half years after three feet of ileum had been resected. Our patient (Case 6) is well, except for auricular fibrillation and three to five stools per day, three and one-half months postoperatively.

Because the series of cases is small, it is impossible to draw any conclusions regarding the value of anticoagulants. However, complications of bleeding in Case 6 could have proved disastrous.

The resectability rate at St. Clare Hospital is 66 per cent; the operative mortality rate, 50 per cent; and the mortality rate of patients not operated upon, 100 per cent.

## Discussion

The cases presented do not differ greatly from the majority of those presented in the literature except for the relatively high incidence of rigidity and the low incidence of shock, a paradoxical finding. The association of cholelithiasis and heart disease with this condition is worthy of emphasis. The resectability rate and mortality rate compare favorably with those in the literature.[5, 6, 9]

Our patient's (Case 6) recent history of gallbladder attacks and elevated icterus index was misleading. Her auricular fibrillation should have given a clue to the possibility of mesenteric thrombosis. The appearance of the bowel suggested that the occlusion was recent and embolic and that the stage of muscular fatigue was approaching. In the 16 hours of symptoms, the mesentery became thickened enough to make palpation of the vessels difficult, and the end arteries had to be divided to determine their patency. The success of the resection was dependent upon this precaution. Dicumarol therapy was delayed five days because of the recent jaundice, and even then there was a rapid and exaggerated response to the drug. The recent liver damage may have been a factor in preventing extension of the thrombus.

Some of the cramps that bother the patient now may be due in part to the narrowing at the site of the anastomosis. It is hoped this will dilate with the rest of the small bowel as time goes on. Antispasmodics were beneficial, but pancreatic and liver enzymes were not.

## Summary

Mesenteric vascular occlusion should be suspected in patients who have severe abdominal symptoms with comparatively few abnormal physical findings. The laboratory and the x-ray are important diagnostic aids. The best chance of cure is early exploration, with adequate resection of the involved segment. Five cases of mesenteric vascular occlusion are presented in summary form, and one additional case of massive resection of the small bowel is presented in moderate detail.

We wish to thank Doctor W. B. Gnagi and Doctor D. D. Ruehlman for their assistance in preparing this report.

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## WISCONSIN DEARHOLT DAYS, NOVEMBER 8 AND 9

Mr. Donald S. King, Hanover, N. H., immediate past president of the American Trudeau Society, will be the 1954 Dearholt Day speaker, the medical department of the Wisconsin Anti-Tuberculosis Association announces. He will speak in Milwaukee on November 8 and in Madison on November 9.

Dearholt Days, held in Milwaukee and Madison each year in early November, are given in honor and memory of Dr. Hoyt E. Dearholt, executive secretary of the WATA from its organization in 1908 until his death in 1939. This marks the 15th year the WATA has brought top medical talent on chest diseases to students at Wisconsin medical schools and all interested physicians.

Modern trends in diagnosis and treatment of pulmonary diseases will be included in Doctor King's talk, which will bring out the marked change in certain conceptions in diagnosis and treatment of chest diseases.

A 1918 graduate of Harvard Medical School, Doctor King practices thoracic medicine with the Hitchcock Clinic, Hanover, N. H. He has been a colonel in the Army medical corps; consultant to the surgeon-general, U. S. Public Health Service; and consultant to the Veterans Administration and the Middlesex and Westfield State Sanatoriums. He is a member of the American Medical Association, American Association of Thoracic Surgeons, and American Clinical and Climatological Association and is a fellow of the American College of Physicians. He has had many articles published in leading national medical journals devoted to chest diseases.

The auditorium of the Marquette School of Medicine will be the site of Doctor King's talk in Milwaukee on November 8 at 3 p.m. The following afternoon at 3 he will speak at the auditorium of Service Memorial Institute, University of Wisconsin Medical School. Both afternoon talks will be for medical students and interested physicians.

At 8 p.m. on November 9, Doctor King will speak at a meeting of the medical societies of Dane and surrounding counties to be held at the VA Hospital auditorium, 2500 Overlook Terrace, Madison.

Cooperating with the WATA on this 15th annual Dearholt Day program are the two medical schools, the Dane County Medical Society, the Wisconsin Trudeau Society, and the Madison VA Hospital.

# Elimination of Water Pollution

## As It Looks to Your State Board of Health

IN 1927, when the Committee on Water Pollution was first organized, most of the municipalities in Wisconsin were discharging untreated sewage to streams. Industries, likewise, were using the streams for disposal of wastes. At that time the Committee, with the State Board of Health as its administrative agency, laid the foundations for a basic program designed to correct industrial waste pollution and to eliminate health hazards due to discharge of untreated sewage, both of which practices were destroying the general usefulness of our streams.

This basic program was effective in gaining construction of many municipal sewage treatment plants which by 1941 provided treatment for 90.4 per cent of the sewage from the population then connected to sewers. Progress in industrial waste treatment was being gained through the cooperative research of industrial groups such as the Pulp and Paper Advisory Committee on Waste Disposal and the National and Wisconsin Canners associations.

The outbreak of World War II and its accompanying reduction in availability of construction materials for civilian purposes definitely slowed down the program at a time when population and industrial growth skyrocketed. In 1949, the public demanded that a more concerted effort be made to reduce pollution of the surface waters of the state. The legislature promptly strengthened the water pollution control laws and increased the appropriation, thus permitting establishment of a full-time Division of Water Pollution Control in the State Board of Health.

The division immediately engaged in detailed surveys to determine sources of water pollution and condition of receiving streams in order to obtain factual information of value to the Committee in establishing the policy and procedure to be followed in each drainage basin. As of January 1, 1954, surveys had been completed in 76 per cent of the area of the state; and orders were issued requiring abatement of pollution. Forty orders were issued in 1949, 50 orders in 1950, 121 orders in 1951, 238 orders in 1952, and 150 orders in 1953. It is anticipated that about 175 orders will be issued in 1954 as a result of surveys completed in 1953. The rate of satisfaction of orders is steadily increasing, with 19 orders satisfied in 1950; 21 satisfied in 1951, 46 satisfied in 1952, and 82 satisfied in 1953.

In 1949, there were 58 communities in Wisconsin which were discharging untreated sewage to streams. Twenty-one of these completed new plants by the end of 1953, and seven had plants under construction. The remainder are in various stages of engineering design or plan preparation. During the same period, many communities with existing treatment plants provided enlargements or additions; and a number of others formerly without sewer systems provided sewers and treatment facilities.

The cooperative industrial waste treatment research program is also bringing results through the full-scale development of yeast fermentation and through evaporation and burning facilities for utilization of spent sulphite liquor produced by the pulp manufacturing industry. One full-scale yeast fermentation plant is now producing 14,000 pounds of yeast per day, and another to produce 28,000 pounds per day is nearing completion. Three evaporation and burning plants have been installed at pulp mills to produce fuel from the spent liquor which was formerly discharged to streams.

Through research, several methods of treatment or disposal of cannery wastes have been developed and are being installed at Wisconsin's many canneries. As a result, we can soon expect to see the day when no cannery will be discharging untreated wastes to a stream.

The dairy industry is being encouraged to enter into similar research programs to seek out methods of utilization or treatment of wastes. Though some of the pollution problems of this industry have been solved, the help of the industry is needed in developing solutions to some of the more difficult problems.

The combined efforts of industries, municipalities, and the Committee on Water Pol-

lution and State Board of Health have brought about measurable improvement in certain of our streams, having in some instances restored the usefulness of small streams for agricultural and recreational purposes and, in the case of larger streams, improved the quality of the water for industrial purposes as well.—T. F. WISNIEWSKI, *Director, Division of Water Pollution Control.*

## WISCONSIN CONFERENCE ON THE PROBLEM DRINKER IN INDUSTRY

Marquette University School of Medicine and the Wisconsin Council on Alcoholism have announced a conference on the problem drinker in industry to be held on November 11, 12, and 13 in Milwaukee.

The conference schedule is as follows:

**THURSDAY EVENING, NOVEMBER 11**

6:30 p.m.—Dinner, Wisconsin Club—Richard S. Falk, Assistant to the President, Falk Corporation, presiding

7:30 p.m.—Address—"Top Management—Wake Up!"—Mr. L. B. Hunter, President, Inland Steel Container Corporation, Chicago, Illinois

**FRIDAY MORNING, NOVEMBER 12—Marquette University Medical School Auditorium**

9:00 a.m.—Welcome—John Hirschboeck, M. D., Dean, Marquette University School of Medicine, presiding

9:15 a.m.—"Magnitude of the Problem"—Mr. Mark R. Kilp, Executive Director of Wisconsin Council on Alcoholism

10:00 a.m.—Question period

10:15 a.m.—Recess

10:30 a.m.—"Profile of an Alcoholic"—Mr. Mark R. Kilp

11:15 a.m.—Question period

12:15 p.m.—Luncheon—Marquette Union

**FRIDAY AFTERNOON, NOVEMBER 12—Marquette University Medical School Auditorium**, Rufus K. Schriber, President, Wisconsin Manufacturers Association, presiding

1:30 p.m.—"Physiological Nature of the Problem"—Leon Greenberg, Ph.D., associate professor and research assistant in physiology, Yale Center of Alcohol Studies

3:00 p.m.—Question period

3:25 p.m.—Recess

3:40 p.m.—"Psychological Nature of the Problem"—Edward T. Sheehan, M. D., professor, psychiatry, Marquette University School of Medicine; psychiatric consultant, U. S. Veterans Administration

4:30 p.m.—Question period

**FRIDAY EVENING, NOVEMBER 12—Public Service Building Auditorium** (Between Second and Third Streets on Michigan Avenue)

8:00 p.m.—"The Sociologist Looks at the Alcoholic"—Denis McGenty, Ph.D., field representative, National Conference of Christians and Jews

**SATURDAY, NOVEMBER 13—Marquette University Medical School Auditorium**, Mr. Wm. A. Roberts, President, Allis Chalmers Manufacturing Company, presiding

8:30 a.m.—"Religion's Role"—Rev. John Ford, S. J., professor of moral theology, Weston College, Weston, Massachusetts; lecturer, Yale School of Alcohol Studies

9:45 a.m.—Question period

10:00 a.m.—Recess

10:15 a.m.—"The Allis Chalmers Approach"—Henry Mielcarek, manager, personnel services, Allis Chalmers Manufacturing Company

11:00 a.m.—"Some Specific Techniques in an Industrial Program"—Edward L. Morris, Executive Director, Portal House of the Chicago Committee on Alcoholism

12:00 noon—Question period

12:30 p.m.—Summary and award of certificates—Mr. Mark R. Kilp
Very Rev. Edward J. O'Donnell, S. J.

(certificates of attendance and completion will be awarded to all who attend the entire conference).

Registrations will not be accepted for part of the conference nor will visits to individual lectures be permitted except on invitation from the directors. Each registrant will pay a fee of $17.50 to cover registration, tuition, opening banquet on Thursday evening, and luncheon at Marquette Union on November 12. Other meals will be available in the Marquette Union at nominal cost. The following hotels have allocated rooms for registrants of the conference: Astor, Ambassador, Plankinton House, Pfister, Schroeder. Registrants will make their own reservations with the hotel of choice at the earliest possible date, mentioning this conference.

Applications for admission must be filed by November 5. Applications and other correspondence related to the conference should be addressed to either Industrial Management Centre, Marquette University, Milwaukee, or Wisconsin Council on Alcoholism, 119 East Washington Avenue, Madison, Wisconsin. Checks in payment of fees should be made payable to Marquette University, 606 North 13th Street, Milwaukee 3, Wisconsin.

# THE WISCONSIN MEDICAL JOURNAL

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# « « « EDITORIAL » » »

## Technologists, Technicians, and Licensure

The medical clinical laboratory technologist is the product of research in physical sciences. He is not the only technologist who has been forced onto the stage of applied science. Skilled, especially trained technologists are required in many fields of endeavor where developments have produced special apparatus, tests, and technics; and medicine is not the only profession that has recognized the need of this group of workers.

Today and almost every day new apparatus is devised by investigators for the exploration of new fields of human physiology or pathology or to examine new methods of approach to obscure problems and hitherto undeveloped methods of investigation. Tomorrow some of this apparatus and some of these technics are brought into the practice of medicine as applied science. Thus, further specialization among medical technologists is to be expected. There are now technologists who are specialized in radiology, physiology, physical therapy, occupational therapy, and clinical laboratory technology. Among the clinical laboratory technologists there are those who specialize further in their own field in the preparation of tissues for microscopic examination, in the field of hematology, in cancer cytology, and in many other divisions of technical practice important to medical diagnosis and to the treatment and control and prevention of disease. Very recently, rapid advances in medical sciences have added significance and importance to this group of laboratory workers.

Because of this, questions are being raised concerning the status of these workers in relation to the physician; and problems are created concerning their individual status and training. One of these is the question of licensure. Is it advisable or necessary to license the medical technologist or otherwise give him a certificate that recognizes his training and skill? Most certainly recognition is necessary, but licensure is not the way to accomplish it. A license carries the import, particularly among the public, of a privilege to practice. It sets the group up by statute as an independent group that can and is permitted by law to operate outside and independently of the Medical Practice Act.

In many technical fields such approval is desirable and necessary since in these instances skillful

practice of a technic constitutes the consummation of the practice as a whole. In the practice of medicine, technical practices executed in the clinical laboratory do not answer all of the questions involved in the diagnosis and treatment of the individual patient, nor do the results obtained by the medical technologist bring together all the details and data which are pertinent to the individual case. It is not alone and by itself the consummation of all medical knowledge, and any form of recognition which actually confers or implies any such self-sufficiency in these practices is fallacious, misleading to the public, and may result in quackery.

However, the medical technologist occupies an important place by the side of the physician in the practice of medicine. This honorable and important position should be recognized for the benefit of both the technologist and for the protection of the physician and the public. The method of giving it must be through the medical profession itself, for it is the profession which requires the aid of the technologist; and from this group, through its organizations, certification of skill and personal qualities of integrity and reliability should emanate. The pathologist in charge of his laboratory, the hospital through the laboratory, and the practicing physician in his office, sponsor and accept the responsibility for the reliability of their laboratory results.

The public relies upon that source of responsibility to guarantee competent medical service. The responsibility cannot be shifted to others, and for that reason it is necessary that some method be developed by which laboratory technologists can be selected on the basis of proved skill and technical knowledge. Standards that accomplish this necessary assurance to physicians and to bring about proper recognition of the technologist have already been set up. The American Society of Clinical Pathologists, in conjunction with the American Medical Association, has established a registry for trained medical technologists and hospitals. Training courses which conform to the educational requirements established by the ASCP for registry eligibility are being conducted for this personnel by universities and colleges throughout the country. The requirements are high enough to insure sufficient understanding of the biologic background of the technical practices to provide an intelligent approach to their skillful and reliable execution. Those applicants who satisfy the educational requirements and pass the ASCP registry examinations are granted a certificate of Medical Technologist, M.T. This is recognition for the technologist from the group with which he is to work and is a testimonial of the education and training background suitable in his work.

Unfortunately there are schools and other agencies that do not require the same high standards of education and personal adaptability as those set up by the ASCP registry. These agencies having lesser standards do confer recognition upon their graduates with titles which sometimes come very close to the title used by the ASCP registry. Thus, the title of Medical Techn*ician*, M.T., can easily be confused with Medical Techn*ologist*, M.T., and yet the education and training received may differ widely.

In Wisconsin, representation has been made to the legislature for legislation requiring licensing of medical techn*icians*. This would put techn*icians* in the same class with techn*ologists* as defined by the ASCP registry and thus remove control from the medical profession of the education and training requirements essential to competence for this group of aides to medical practice.

Licensing medical technologists opens up hazards which should be avoided. Certification by standards set up by the profession and maintained through approval of schools offering courses to these students and by examination for registration is the logical method by which to develop a group of competent subsidiary workers in this field of medical practice.—W. D. Stovall, M.D.

## UNIVERSITY OF MINNESOTA SCHEDULES CONTINUATION COURSES

The University of Minnesota has announced the following continuation courses to be held during October and November. Both courses are to be held at the Center for Continuation Study on the University of Minnesota campus.

**October 28–30—Dermatology for Specialists**

The program will deal with topics of current interest to practicing dermatologists, with special emphasis being placed on sarcoidosis.

*Under direction of:* Dr. Henry E. Michelson, Professor, Department of Medicine, and Director, Division of Dermatology.

**November 4–6—Anesthesiology for General Physicians**

The course will deal with all types of anesthetic technics, including those used in obstetrics. Newer anesthetic agents will be discussed.

*Under direction of:* Dr. Frederick H. Van Bergen, Associate Professor and Acting Director, Division of Anesthesiology.

Dr. A. J. McCarey, new president of the State Medical Society, was born in Antigo on September 9, 1888. He received the degree of Bachelor of Science from the University of Chicago in 1910 and his medical degree from Rush Medical College in 1912. He served his internship at the Hospital of St. Anthony de Padua in Chicago. A general practitioner and surgeon, Doctor McCarey has practiced in Green Bay since 1919.

During World War I, he served with the 4th Division in England, France, and the Army of Occupation in Germany. He was awarded a citation by General Pershing for exceptionally meritorious and conspicuous services in the American Expeditionary Forces and was also awarded the Purple Heart.

Active in local and state medical societies, Doctor McCarey has served as Councilor from the Sixth District, member of the House of Delegates, and former president of the Brown–Kewaunee–Door County Medical Society. He is a Fellow of the American College of Surgeons, founder member of the Wisconsin Surgical Society, Fellow of the American Medical Association, and president of the Green Bay Board of Health. Green Bay hospitals of which Doctor McCarey is a staff member are St. Mary's and Bellin Memorial; he is visiting surgeon at St. Vincent's Hospital.

# Minutes of the Council Meeting, Wisconsin Rapids May 15 and 16, 1954

**1. Call to Order**

The Council was called to order by Chairman Arveson at 2:30 p.m., Saturday, May 15, at the Mead Hotel, Wisconsin Rapids.

**2. Roll Call**

Councilors present were Doctors Costello, Hemmingsen, Hill, Kasten, Dessloch, McCarey, Fox, Garrison, Arveson, Ekblad, Galasinski, Bernhart, Casper, Wegmann, Zellmer, and Past-President Griffith.

Also present were President Tenney; Treasurer Weston; Speaker Simenstad; Vice-Speaker Fons; Doctor Gundersen, Board of Trustees, American Medical Association; Doctors Stovall and Witte, AMA delegates; Dr. C. N. Neupert, state health officer; and Dr. J. M. Sullivan, chairman of the Committee on Public Policy.

Staff members present were C. H. Crownhart, secretary; R. T. Ragatz, assistant secretary; E. R. Thayer, assistant secretary; Robert B. Murphy, legal counsel; W. C. White, Jr., consulting actuary; Paul R. Doege, sales coordinator; T. J. Doran, claims director; R. E. Koenig, manager of statistical division (the last three Sunday only); and Misses Joan Pyre and Jean McGruer of the Society's office.

**3. Report of Board of Trustees of the SMS Realty Corporation**

The secretary provided a report on behalf of the Board of Trustees, which met on May 5, 1954. The Board of Trustees consists of Doctor Dessloch, president; Doctor Tenney, vice-president; and Doctor Hill, treasurer. The secretary of the Society serves as secretary of the corporation.

All councilors and officers, who, by virtue of their position in the State Medical Society, are members of the SMS Realty Corporation, were advised by letter of the results of bids for construction of the new office building of the Society. They were asked to advise of their reactions; all but three replied. Those who replied had favorable reactions, although two suggested holding the matter for discussion at the Council meeting in May. Under bid specifications, acceptance or rejection was required within thirty days after opening; and thus it was impossible to hold the subject for discussion at the May meeting.

The Trustees reviewed all bids with assistance of the architect and others and, by formal resolution, unanimously carried, awarded a contract to each of the low bidders. Other action taken was of related character. It included formally authorizing its officers to execute a construction loan and directing the secretary to negotiate construction insurance and to start negotiations looking toward the disposition of present property, with occupancy available to the purchaser in midsummer of 1955. The Trustees also authorized the preparation of debentures which could be made available to interested county medical societies and to physician members as a secondary source of financing.

The secretary pointed out that before funds could be released under the construction loan, the bank required release of available SMS securities to the SMS Realty Corporation and that Council action should be taken to authorize such a step.

> On motion of Doctors Bernhart-Galasinski, carried, the treasurer was authorized to liquidate securities and transfer unallocated cash to the SMS Realty Corporation.

The secretary reported that the new office building should be completed about June 1, 1955. He emphasized that certain operating equipment needs would not be determined until there was actual experience in the use of the building.

**4. National Rural Health Meeting**

Mr. Thayer presented a request of the Council on Medical Service that it be given permission to invite the AMA Council on Rural Health to meet with it and invited guests for the initial planning session relating to the National Rural Health Conference to be held in Milwaukee, February 24, 25, and 26, 1955.

The State Medical Society Council on Medical Service believes that the Society can make a significant contribution to the planning of this conference if all members of the Council on Medical Service, together with some farm leaders and members of the general Council, attend. Mr. Thayer explained that it would probably be a one-day meeting, with the American Medical Association paying expenses of members of its Council and National Advisory Committee, and that the contemplated meeting would involve no special expense to the State Medical Society, except that for dinner for about 30 people.

> The Council expressed its approval of the request by motion of Doctors Griffith-Kasten, carried, granting authority to the Council on Medical Service to hold such a meeting.

**5. Press Association Health Promotion Plan**

Mr. Thayer reported for the Council on Medical Service that the Wisconsin Press Association, in its desire to promote better health practices throughout the state, proposes to assist in achieving periodic health examinations for the people of Trempealeau County as a test program. It proposes a program of combining advertising and editorial material to carry out the project.

By formal action, the Council on Medical Service recommended that the physicians of Trempealeau County cooperate with the press of that county in a trial program for the promotion of health examinations, with the understanding that the program do nothing to establish or imply that fees are being established for routine physical examinations.

Action of the Council on Medical Service included making recommendation that the State Medical Society staff work closely with the Wisconsin Press Association in the development of this project.

On motion of Doctors Hill-Zellmer, carried, the Council acted to approve the recommendations.

**6. Wisconsin Public Health Council**

The Wisconsin Public Health Council, an organization created to stimulate the establishment of local voluntary health councils, is to be reorganized and operated as a corporation, with increased activities and dues structure planned.

The Council on Medical Service has been interested in the reorganization, has reviewed material concerning it, and recommends that the State Medical Society, which is now a member, become a charter member of the new organization. Mr. Thayer pointed out that the cost will be $100 annually, as compared to the present cost of $50, plus $2 for each member of the State Medical Society Council and for each officer.

In the discussion which followed, Doctor Neupert said he felt there was a function for a voluntary agency made up of community councils, that in the community councils there should be opportunity for good leadership by physicians, and that he believed physicians would want to have a part in finding out what the health problems are in local communities.

On motion of Doctors McCarey-Bernhart, carried, the Council approved the recommendation that the State Medical Society become a charter member of the new Wisconsin Public Health Council.

**7. Safety Belts—Automobiles**

The Council on Medical Service, at its April 25 meeting, recommended that the State Medical Society issue a public statement endorsing the use of safety belts in automobiles, particularly in the right front seat. It was stated further that this statement would be supported by appropriate statistics and other information.

There was considerable discussion of this subject, during which Mr. Thayer pointed out that it had come to the attention of the Council in a study of accident prevention, in which the belief was expressed that, because the public generally was not acquainted with the device, it would be proper for the Society to call attention to the fact that it would be a good and also inexpensive method to reduce injuries and death due to automobile accidents.

On motion of Doctors Galasinski-Kasten, carried, the Council directed that the subject be referred back to the Council on Medical Service for further study and for a more detailed report.

**8. Pharmacy**

There was general discussion of the subject of the pharmacist and the practice of medicine.

On motion of Doctors Kasten-Zellmer, carried, the current position of the State Medical Society was affirmed.

**9. Hearing Conservation Guide**

Doctor Arveson called on Mr. Ragatz to present recommendations of the Division on Visual and Hearing Defects. He reported that a subcommittee of that division had prepared a guide for the use of Wisconsin industries concerned with hearing loss and the necessity of compiling records on workers, in connection with Workmen's Compensation, and that the importance of such a guide has been emphasized by both industry and insurance carriers.

Mr. Ragatz reported that institutes have been arranged to train individuals in audiometric testing in connection with pre-employment examinations and that several industries now require audiometric testing with employment applications.

The subcommittee believes it imperative that medical guidance be provided as quickly as possible and recommends that the guide become an official statement of the State Medical Society of Wisconsin.

It is proposed that the initial printing order be 5,000 copies, with distribution through a special mailing to all Wisconsin industries of sufficient size to suggest need for such a program. It is anticipated that there will be great demand for the guide from industries outside of Wisconsin, as this state is leading the way on this important industrial problem.

An additional part of the program will be the preparation of a panel of EENT members who agree to render the services under the terms outlined in the material presented to the Council. The printing and distribution of panels on an annual basis will be an additional expense but one which is essential to the value of the program.

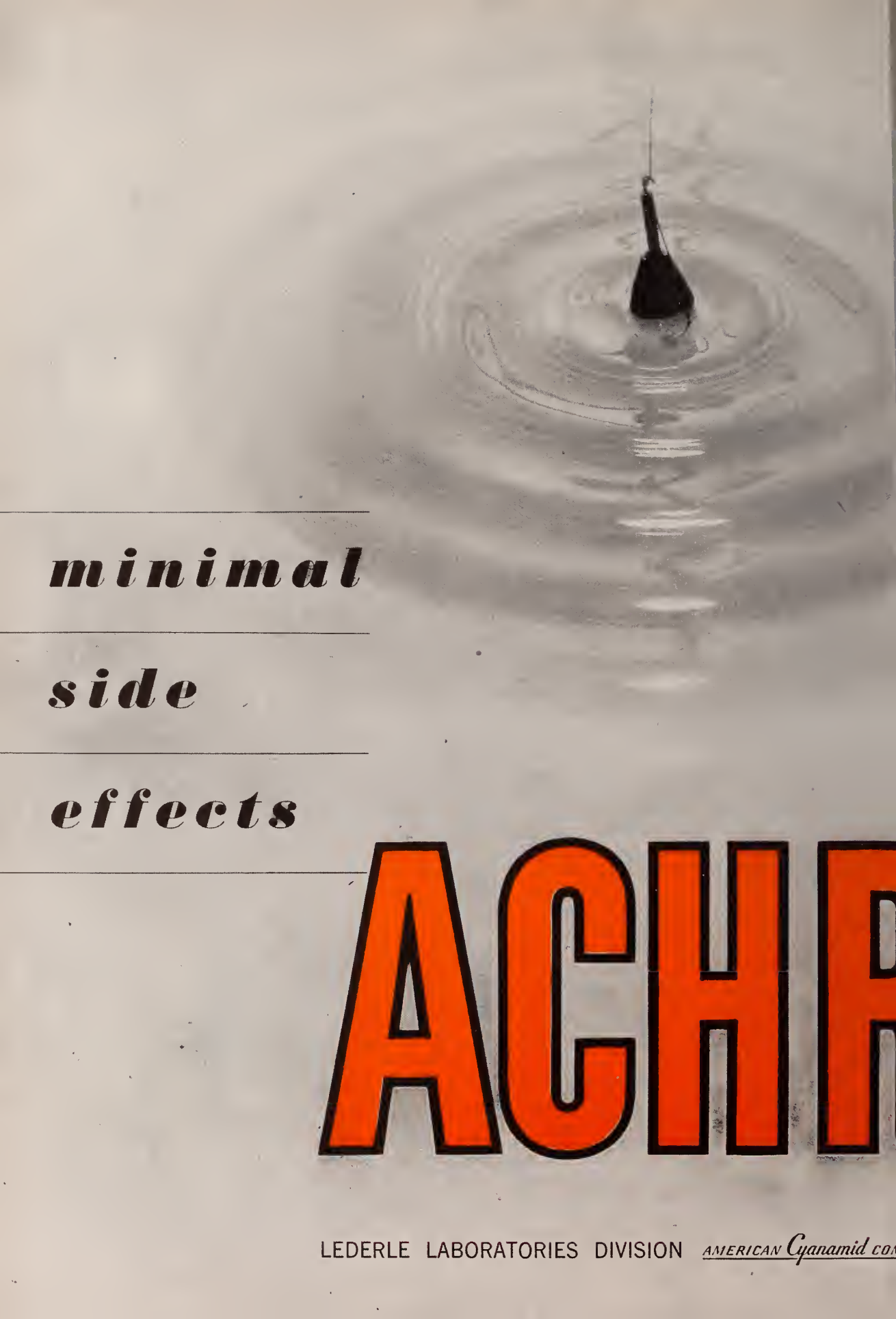
Mr. Ragatz reported that the budget included allocation for this project and, while it is unlikely that this will completely cover the cost, some assistance was anticipated through the sale of reprints.

On motion of Doctors Dessloch-Hill, carried, the Council approved the guide as presented and authorized its printing and distribution as outlined.

**10. Report of the Secretary**

The secretary reported on various activities within the Society committees and staff and, in particular, called attention to an exhibit prepared in connection with the Section on Medical History. The exhibit will be taken to various meetings and clinics in the

*(Continued on page 562)*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hope of interesting more physicians in membership in the section.

Mr. Crownhart reported on results of the membership questionnaires. He said the response to date had been extremely gratifying and that many interesting comments and letters had been received concerning the questionnaire and various phases of Society activity.

A special report involving files 54-5 and 54-13 was reviewed by the secretary and was formally approved by the Council.

In attempting to keep the Council informed on activities, the secretary spoke of the school health conferences, two of which have been held, with two more scheduled; and he called for collaboration in an evaluation of the conferences from President Tenney.

Doctor Tenney said, "Our interest in a school health program stems from the belief, for one thing, that health is not simply the absence of disease, but involves every part of man's activity, and that the requirement of good health conditions in the school is an assurance to parents that the chance for preventive medicine in the schools is excellent."

Doctor Tenney said that through the school health conferences the medical profession has an opportunity to demonstrate good health activities and make sure that good health education is carried out in the schools; that while the State Medical Society recognizes the importance of the preventive medicine angle in the schools, frequently it does not have a chance to influence communities by individual efforts; and that with the school health conferences and the combined effort with school people, those in public health, parent-teacher associations, etc., a much broader application of preventive medicine is possible.

**11. Interim Committee Recommendations**

*A. Blue Shield and Blue Cross for Physicians.* While a number of physicians are enrolled in these plans, no "state" association group has been formed for this purpose. Physicians are enrolled through county medical societies, hospital staff organizations, and other mechanisms.

The Interim Committee recommended enrollment of those physicians desiring such coverage through a state group, with a common enrollment date each year. On approval, the matter would be referred to the Commission on Prepaid Plans for final development.

> On motion of Doctors Hill-Zellmer, carried, the recommendation was approved by the Council.

*B. Proposal of Wisconsin Committee of the Health Insurance Council.* The Commission on Prepaid Plans met recently with a representative of the Health Insurance Council, who asked that a "trial run" relative to the utilization and incidence problems and their implications as to voluntary prepayment plans be sponsored in Wisconsin next fall. Such a program would be developed under direction of the Commission and would represent a joint effort on the part of Blue Shield and the Health Insurance Council. Meetings would be scheduled with a small number of county medical societies, and an organized program would be developed.

The Interim Committee favored such a proposal and recommended Council approval.

> On motion of Doctors Hill-Galasinski, carried, the Council acted to approve the recommendation.

*C. SMS Foundation.* The secretary and legal counsel upon three occasions discussed a proposal to organize within the State Medical Society a scientific and educational foundation which would be sufficiently flexible so that, as changing times require, it could direct its activities in special fields but not necessarily permanent fields.

The present need of the Student Loan Fund is increasingly apparent; but within a decade or so, there may be little reason for its existence and yet no reason to liquidate the fund in view of new developments that might then appear.

At the present time, for example, the House of Delegates of the American Medical Association urges state medical associations to bill members an annual $20 voluntary assessment for the American Medical Education Foundation. Were the SMS Foundation in effect, contributions could be directed to the Education Foundation on behalf of Wisconsin physicians.

Fund raising is a unique technic in itself; and unless there are concerted efforts in this direction carried on at regular intervals, such a program seems to be relatively nonproductive.

The staff proposed a device, which the Interim Committee favors, that each physician member between his 45th and 55th (inclusive) years of age be billed annually an additional sum, payment of which is wholly voluntary and the proceeds of which would go to the SMS Foundation. By augmenting the device further from other sources, a ten-year development of the program could produce a substantial amount in the trust fund, even with nominal, voluntary contributions by physicians. It was explained that ultimate consideration by the House of Delegates would be necessary.

In a discussion of the proposal, it was emphasized that the fund would be used only for scientific and research activities.

> It was moved by Doctors Dessloch, Zellmer, and Costello that the staff be authorized to develop the details and machinery for the SMS Foundation and to report its recommendations to the Council at its July meeting.
>
> Doctors Bernhart-Ekblad moved an amendment that the details include physicians who are 35 years of age and over and in active practice.
>
> The motion as amended was then put to a vote and carried.

*D. Recommended By-Law Changes Re House of Delegates Meeting.* This subject was generally con-

sidered at the November 1953 meeting. It was returned to the Interim Committee, which was directed to meet with officials of the House of Delegates to obtain their reaction. The Interim Committee held such meeting and recommended the following proposals for transmission to the House of Delegates:

(a) A By-Law resolution be offered to the House of Delegates requiring each county society to elect its delegates and alternates to serve a term of at least one calendar year and requiring, in any event, that the term of office expire on December 31 of a particular year.

*(Note:* This is consistent with the pattern of the AMA and means that no matter when a delegate is elected, he takes office on the following January 1 and serves through December 31 of the year in which his term expires.)

(b) It be a standing rule of the House of Delegates that whoever is seated to represent a county medical society serves as delegate for the entire session, with the privilege, however, of the elected alternate being seated at any subsequent session upon recommendation of the Credentials Committee.

(c) Credentials be distributed direct to delegates rather than being routed through the county secretary as at present.

(d) Those registered for attendance at the House of Delegates other than as voting delegates be provided with special registration slips.

(e) The present By-Law providing that the number of fully paid members as of a date 30 days in advance of the first session shall determine the number of delegates to which a society is entitled be changed so that such determination is made upon the number of fully paid members as of the close of the prior fiscal year of the State Medical Society.

(f) The Credentials Committee be seated at the registration table to handle such problems as may arise.

On motion of Doctors Hemmingsen-Hill, carried, the Council approved the recommendations for transmission to the House of Delegates.

E. *Councilor District Meetings.* At the present time Councilors are under mandate of the House of Delegates to arrange a caucus of delegates within their district, this caucus to be in advance of the Annual Meeting, with arrangements made so that matters coming before the House may be presented in detail.

With the change in the 1955 Annual Meeting date, a different arrangement may produce more effective results and generally benefit the organization of the Society. It has been common in many areas to arrange district meetings of the societies within a councilor district; and exclusive of Milwaukee County, which is a district within itself, there are four or five districts which adhere to that custom. Others have no district organization of any sort.

A proposal which met with Interim Committee approval is that the staff of the Society, working with the Councilor in each of the districts, arrange district meetings for broad attendance and with a program directed at matters of medical economic concern. An essential part of these meetings would be a review of the more important matters coming before the House of Delegates.

These meetings would be held within a sixty-day period prior to the 1955 Annual Meeting, and attendance of Society officers and executive staff would be arranged.

On motion of Doctors Hill-Dessloch, carried, the Council approved the proposal for 1955 and requested that the results be evaluated and reported back for further instructions.

F. *Physicians Appointed to Blue Cross Membership.* In accordance with section 180.32 of the Statutes of Wisconsin, under which Associated Hospital Service, Inc. operates, the physicians and surgeons who are appointed to membership in that organization are subject to the approval of the State Medical Society of Wisconsin.

Associated Hospital Service submitted a list of newly appointed physician members for approval of the Society.

After discussion, on motion of Doctors Wegmann–Bernhart, carried, the nominations of proposed new members of the corporation submitted by Associated Hospital Service, Inc. were referred to the Commission on Prepaid Plans for review and recommendation back to the Council.

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*The Council recessed at 9:30 p.m., Saturday. Doctor Arveson announced that he would not be able to be present for the Sunday session and requested Doctor Dessloch to serve as chairman in his absence and for the balance of the agenda.*

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**12. Report of the Commission on Prepaid Plans**

The following report was presented to the Council:

## INTERIM REPORT—COMMISSION ON PREPAID PLANS OF THE STATE MEDICAL SOCIETY

*Agency Contract With Blue Cross.* Effective January 1, 1954, the Commission entered into a new agreement with Blue Cross as agent for the State Medical Society in the sale of Blue Shield. Of greatest importance to both parties is the amount of reimbursement, which stands agreed at $.2119 per contract per month, subject to adjustment based on cost of living index. Formerly, reimbursement was figured on the basis of total costs of Blue Cross, with certain agreed exceptions, being shared between the two Blue Shield plans and Blue Cross in the proportion that the contracts of each plan bore to the total of all contracts. Months of negotiations were involved in the renegotiation of the agency contract. Your Commission is not satisfied that the amount being paid to Blue Cross represents the best price available to Blue Shield; but it was the only price offered by Blue Cross, and there was no com-

petitive bid on this contract. The Commission feels, however, that as further experience is gained Blue Cross costs in the sale of Blue Shield may become demonstrable.

Second in importance to the cost factor is the new contract provision providing for much longer notice should either party decide to cancel the agency relationship. Against the old provision of a 90-day notice, there now stands a six-months' notice, plus agreed arrangements providing for an orderly windup of the relationship. Other contract provisions have been clarified, and the whole relationship between Blue Cross and Blue Shield stands on firmer ground insofar as legal documents are concerned. Only the spirit of cooperation between both parties, however, can effectuate the technicalities of legal draftsmanship. The effect of the new contract upon the spirit and interest of the parties will be demonstrated, it is hoped, in a marked growth of Blue Shield in 1954.

*New Benefits Now Available.* By the payment of an additional rate, subscribers to Blue Shield can now obtain:

1. Surgical benefits for the newborn (restricted to those 14 days of age in the standard contracts).
2. A percentage increase of all benefits for those individuals enrolled under group protection whose income is higher than that qualifying such individuals for "full payment."
3. Extension of medical care in the hospital for 30 days, the standard provision, to 70 days or 120 days.

*Experiments "in the Making."* The Commission feels that Blue Shield is not fulfilling the purpose for which it was created if it only provides the usual benefits expected in prepaid surgical and medical plans today. Research and study must be constant; and when the paper work has been completed, some experimental programs must be tried as a laboratory test. Students of this type of insurance often insist that the program is not complete without some provision for benefits in the dental field other than for the preservation and care of teeth. Outpatient diagnostic work-ups offer another field of investigation, as do therapeutic x-rays and certain benefits for home and office medical (as distinguished from surgical) care.

During the course of 1954 the Commission expects to issue a rider to its standard contracts providing certain of these benefits. Installation will be controlled to approximately 5,000 contracts; and after actual experience with that rider, the Commission will be in a position to offer its conclusions and recommendations to the Society.

> On motion of Doctors Ekblad-Hill, carried, approval was given to the issuance of such a rider on a trial basis.

*A New Contract About Ready.* Several years ago, in response to negotiations of the auto industry, Blue Cross developed a special contract known as the "auto contract." It extends benefits for hospitalization to 120 days and provides for the cost of therapeutic x-rays when rendered in and billed by a hospital. In an effort to assure the fact that expanded physicians' benefits would be available in connection with the "auto contract" of Blue Cross, the Commission authorized extension of in-hospital medical care to 120 days at the option of the purchaser. The development of a special Blue Shield rider for therapeutic x-ray has also been authorized. These extensions of benefits will be offered to all groups expressing an interest in the Blue Cross 120-day coverage.

> On motion of Doctors Hill-Kasten, carried, the Council acted to approve a Blue Shield "auto contract" similar to that of Blue Cross already in effect.

*Conservation and Protection of Blue Shield.* It is a matter of common knowledge that Blue Cross has frequently been involved in raising its rates. A Blue Cross rate increase always involves some adverse effect upon Blue Shield. Many subscribers look upon their package of Blue Shield and Blue Cross as one operation. Where costs become too burdensome in the judgment of some subscribers, their option is to drop one or the other plan; and to the best knowledge of the Commission, there are no group subscribers only to Blue Shield. These and other matters clearly sustain the Commission's decision to bolster Blue Shield. Upon the purchase of Blue Shield by groups, individually typed letters are sent the proper official over the signature of the chairman of the Commission. Separate Blue Shield literature is being devised not only as sales promotion but equally for the conservation of sales already achieved. In addition to these projects, further personnel is being employed. The first step in this direction has been accomplished; and after a period of "internship" in the Blue Shield office, an assistant will be located in Blue Shield offices to be separately maintained in the Fox River Valley area.

The primary responsibility of this particular individual, under direction of the Madison office, will be in the servicing of installations already acquired. The word "servicing" implies personal contacts necessary to eliminate misunderstandings and to assure that new employees are being enrolled properly and with understanding of plan benefits, and that the plan is being effectively represented at those times when plant management may "open up" renegotiations of its insurance program. It is not expected that this individual, or others who may be added at a later date, will be concerned primarily with the acquisition of new sales. However, where there are known installations of Blue Cross without Blue Shield, this individual along with others in the employ of the Society, working in cooperation with Blue Cross, will emphasize the desirability of adding Blue Shield to the Blue Cross installation. Within

the limit of funds available, and with a careful development of this type of conservation program, it is within the Commission's planning to add others to the payroll in the ensuing year or so. The value of this type of activity cannot be fully measured by the tangibles, but there are ways to judge its effectiveness; and the Commission plans on further reporting to the Council at subsequent dates relative to this particular project.

*An Experimental Program in Northwestern Wisconsin.* The measure of success of a program is not necessarily its size; and obviously the Commission on Prepaid Plans cannot hope to develop the largest plan in the country, but it can hope to develop one of the best.

Wisconsin's population still remains approximately 50 per cent rural and 50 per cent urban; but since Blue Shield of Wisconsin is not sold within Milwaukee County, it is obvious that its market is essentially in the rural areas. This means that Blue Shield must reach small groups and individuals. But so far in its development it has been pretty much confined to the enrollment of groups only. Out of a total of 121,276 contracts at the end of March, only 8,106 were non-group contracts.

Reaching the individual who can enroll in Blue Shield through the non-group device poses a sales problem of considerable consequence. Several devices appear feasible. One was tried in the fall of 1953 in the eastern part of the state and will be under way again in Monroe County (Sparta–Tomah area) at the time of this meeting of the Council. It is called a community enrollment program, which implies concentrated advertising and sales personnel, with various community types of endorsement, promoting contracts within a defined geographic area, within a limited period of time.

Another device is mass media advertising, which seems more successful in good will promotion than in the actual acquisition of a risk. Direct mail campaigns have not been used by WPS but may prove successful to a certain extent.

A third device is being undertaken by Blue Shield itself and will be operated as a sales experiment during the next several years. Some background is necessary to explain the project. Up to this date Blue Shield has not engaged in any direct sales efforts of its own. The Blue Cross philosophy has been the employment of full-time sales personnel; and, obviously, in the more sparsely settled areas of the state such personnel must be assigned rather large geographic areas, and as a result, they tend to confine their activities to group enrollment.

Blue Shield believes that it may be possible to develop the program through part-time personnel, and that will be the effort in northwestern Wisconsin. The Commission has authorized its staff to work out arrangements in that area so that some individuals may, on a part-time basis, develop applications for Blue Shield and Blue Cross from those who are ineligible to enroll in these programs through the group device. The acquisition cost of these contracts will be high, and care must be taken not to defeat the objectives of the program by the issuance of too many riders eliminating pre-existing conditions that may be known to the applicant or by administrative delays in accepting the application and delivering the contract. Blue Shield will have to "cut its teeth" in this particular type of program, which, if it proves successful, will certainly point a way to the further extension of its contracts.

It should be emphasized to the Council that as of May 1, 1954, both Blue Shield and Blue Cross now make provision for maternity benefits in the non-group contract—a long-time objective of Blue Shield, which has withheld the inclusion of those benefits pending Blue Cross decision. A 9-month waiting period is provided in the Blue Shield contract, while Blue Cross requires an 11-month waiting period and limits the total benefit. However, Blue Cross is re-examining its position in this respect; and it is hoped that its current restrictions may be eased after another year. The inclusion of maternity benefits in the non-group contracts should contribute substantially to their desirability.

*Physicians Indemnity Plan and the National Picture.* Events in the indemnity field have moved so rapidly and still so nebulously that the Commission and the staff are confronted with an almost impossible task in providing any summary of the situation.

However, it is imperative that the Council follow this matter as closely as possible and that the implications of it be fully understood.

Several years ago, in the development of the national trade association of Blue Shield and the similar organization of Blue Cross, one of the problems related by larger plans in the East and other areas was that employers who had employees located in various states, and in substantial number, wanted uniform benefits available throughout the installation. It would not agree to the purchase of a number of Blue Cross or a number of Blue Shield plans having varying benefits, some including full payment and others operating strictly on an indemnity basis.

Arising out of that related situation was the movement for the development of a national insurance organization representing both Blue Cross and Blue Shield. With Council approval, Blue Shield of Wisconsin took the position, and many plans joined with it, that any device developed should necessarily be in dual form—one representing and controlled by Blue Shield, the other representing and controlled by Blue Cross. This, in a sense, became the national pattern, with the organization of Health Service, Inc., an insurance company wholly owned by Blue Cross, and Medical Indemnity of America, an insurance company wholly owned by Blue Shield.

To the point that these companies each have their own Board of Directors and are separately owned, they are, in fact, two insurance companies. However, each plan has now agreed to reinsure 50 per cent of the risk acquired by the other, to operate under the direction of a joint operating committee,

and to operate through the mechanism of a single administrative staff. Thus, it becomes apparent that, regardless of legal technicalities, the two plans operate as one. With this organization, the definition of a national risk has been expanded. The Federal Government, as an employer, becomes a national risk. Members of a union that is nationally organized are looked upon as a national risk.

The ultimate impact of these two national companies upon the Blue Cross and Blue Shield movement cannot be adequately gauged at the moment, but it does seem desirable to record to the Council at this point the immediate necessity of Blue Shield plans throughout the country reasserting their control of Medical Indemnity of America.

Because of the development of these programs and the fact that they were beginning to move into Wisconsin, the Commission on Prepaid Plans, acting under prior authority of the Council, immediately moved to the creation of Physicians Indemnity Plan of Wisconsin and made it available to take over those risks in Wisconsin which had purchased benefits made available through Health Service in the first instance, inasmuch as Medical Indemnity of America is not licensed in this state. The Commission did so for a number of reasons.

First, Health Service, with 50 per cent of its risk reinsured by Medical Indemnity of America, successfully negotiated a contract for the employees of two meat processing concerns with a total of about 12,000 persons covered in Wisconsin outside of Milwaukee County. The program so installed was represented as one being underwritten by the nationally known plans of Blue Cross and Blue Shield. Yet the benefit schedules were in many respects quite different from those being offered by Blue Shield of Wisconsin, and it was readily apparent that subscribers and physicians alike would become confused between Blue Shield of Wisconsin and Blue Shield of America to the detriment of both plans as well as subscriber and physician relations. It was possible under the identity of Physicians Indemnity Plan of Wisconsin to eliminate reference to Blue Shield and to keep Blue Shield out of the entanglements which immediately existed and which have become more complex since installation of the plan.

Although Physicians Indemnity Plan has been in effect on two groups in Wisconsin (outside of Milwaukee County) since December 1, 1953, the two national insurance companies have not as of this date (May 7) executed a formal insurance contract. Since the original installation, and as late as mid-April, Health Service and Medical Indemnity were still negotiating upon certain points of the contract. Questions of payments for concurrent surgical and medical care were still uncertain. At the time of installation of the risk, it was confirmed to administrative personnel in Chicago that it was the understanding of PIP that circumcision benefits would not be available during the period in which the mother was also a hospital patient. Two weeks later Health Service concluded that circumcision benefits would not be provided for the newborn during the first 30 days following the date of birth. After another two weeks had elapsed it reversed the field and agreed to include circumcision benefits during the hospital stay of the mother.

The Council should properly inquire of the Commission at this point about as follows: Acknowledging the problem that you have presented, what can be done about it?

The Commission on Prepaid Plans is uncertain just how to proceed. The Council should fully appreciate the tremendous amount of man hours invested in WPS by those physicians who serve on the Commission and its committees. The Commission is satisfied that the administrative staff is closely adhering to the only concept which will make Blue Shield effective—it *is* a plan of the physicians of Wisconsin, and all fundamental policy questions must be determined by the physicians themselves.

What is needed in this country is more general interest on the part of the medical profession and less of an attitude of "let George do it."

As a result of Commission directive and staff activity, WPS is doing its best to make its own contribution to this by developing a program of direct contact with other plans rather than through the mechanism of the Blue Shield national organization.

This report as to Physicians Indemnity Plan is for the record and calls for no action at this time; but it does call upon each councilor and officer for study and then reflection so that as further problems and proposals are made to the councilors and officers, they may view them with the background of knowledge acquired over a period of time and be in a better position to judge their merits.

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*Miscellaneous.* It is estimated that the income of Wisconsin Physicians Service in 1954 will exceed four million dollars. Blue Shield of Wisconsin has passed beyond the infancy stage. Policy and administrative management of an insurance organization having that amount of income is complex and burdensome. The growth of WPS demands not only adequately trained personnel, but physical facilities far beyond those available at the present headquarters. The Commission views with satisfaction the building of headquarters for the State Medical Society of sufficient size as to accommodate the present staff and physical needs of the Society, along with permitting moderate space for expansion.

Following are the latest financial reports of Wisconsin Physicians Service.

Submitted on behalf of the Commission on Prepaid Plans by the Executive Committee:

E. M. Dessloch, M.D., *Chairman*
Robert Krohn, M.D.
J. S. Supernaw, M.D.
H. E. Kasten, M.D.
H. Kent Tenney, M.D.

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**WISCONSIN PHYSICIANS SERVICE**
**Madison, Wisconsin**

**BALANCE SHEET**
**March 31, 1954**

| | | |
|---|---|---|
| **Assets** | | |
| Cash on Hand and in Banks | | $ 455,639.58 |
| Cash on Deposit with Agent | | 116,000.00 |
| Due from Agent | | 157,056.15 |
| Advance to Physicians Indemnity Plan of Wisconsin | | 25,000.00 |
| Refunds Receivable | | 3,067.50 |
| Accounts Receivable | | 6,105.22 |
| U. S. Government Bonds—Net | $1,456,649.52 | |
| Less: Reserve for Excess of Book Value over Market Value | 2,435.72 | |
| | $1,454,213.80 | |
| Accrued Interest Income | 7,271.36 | 1,461,485.16 |
| Office Furniture and Fixtures—Net | | 15,754.63 |
| Deferred Charges | | 316.97 |
| Total Assets | | $2,240,425.21 |
| **Liabilities and Reserves** | | |
| Accounts Payable | | $ 47,789.70 |
| Merit Rating Credits Payable | | 19,657.54 |
| Physicians Claims Payable | | 389,797.20 |
| Reserve for Old Outstanding Checks | | 2,449.50 |
| Unearned Income | | 404,979.80 |
| Reserves—Maternity Benefits | $ 187,800.00 | |
| Disaster Claims | 219,779.00 | |
| Unforeseen Contingencies | 514,758.83 | |
| Administrative | 408,970.19 | |
| Investment | 44,443.45 | 1,375,751.47 |
| Total Liabilities and Reserves | | $2,240,425.21 |

**WISCONSIN PHYSICIANS SERVICE**
**Madison, Wisconsin**

**COMPARATIVE STATEMENT OF INCOME AND EXPENDITURES**
**For the periods January 1 to March 31, 1953 and 1954**

| | 1-1-54 to 3-31-54 | 1-1-53 to 3-31-53 | Increase or (Decrease) |
|---|---|---|---|
| **Income** | | | |
| Earned Premium Income | $1,039,621.27 | $918,087.15 | $121,534.12 |
| Other Admin. Income | 2,412.08 | | 2,412.08 |
| Investment Income | 8,489.13 | 3,834.38 | 4,654.75 |
| Total Income | $1,050,522.48 | $921,921.53 | $128,600.95 |
| **Expenditures** | | | |
| Benefits Incurred | $ 823,613.75 | $732,192.00 | $ 91,421.75 |
| Expenses of Agent | 77,133.83 | 85,653.65 | ( 8,519.82) |
| Salaries | 30,737.38 | 27,109.65 | 3,627.73 |
| Legal Expense | 2,649.10 | 1,604.44 | 1,044.66 |
| Auditing Expense | 1,548.34 | 660.45 | 887.89 |
| Actuarial Expense | 3,278.56 | 1,579.27 | 1,699.29 |
| Conference Expense | 4,122.83 | 2,255.86 | 1,866.97 |
| Staff Travel | 2,387.65 | 866.17 | 1,521.48 |
| Stationery and Supplies | 1,493.18 | 1,313.70 | 179.48 |
| I.B.M. Expense | 3,468.83 | 1,607.36 | 1,861.47 |
| Rent | 2,722.50 | 2,475.00 | 247.50 |
| Office Expenses | 572.10 | 746.62 | ( 174.52) |
| Postage and Express | 1,092.10 | 979.54 | 112.56 |
| Payroll Taxes | 1,168.02 | 894.79 | 273.23 |
| Telephone and Telegraph | 734.82 | 1,091.58 | ( 356.76) |
| Employees' Group Insurance | 411.65 | 373.60 | 38.05 |
| Depreciation | 641.75 | 451.67 | 190.08 |
| Insurance | 113.63 | 123.39 | ( 9.76) |
| Association Dues | 923.23 | 851.79 | 71.44 |
| Conservation and Promotion | 2,296.40 | | 2,296.40 |
| Other Admin. Expenses | 1,146.25 | 277.31 | 868.94 |
| Total Expenditures | $ 962,255.90 | $863,107.84 | $ 99,148.06 |
| Available for Reserves | $ 88,266.58 | $ 58,813.69 | $ 29,452.89 |
| **Distribution of Each $100 of Income** | | | |
| Benefits Incurred | $ 78.40 | $ 79.42 | $( 1.02) |
| Expenses of Agent | 7.34 | 9.29 | ( 1.95) |
| Other Admin. Expenses | 5.86 | 4.91 | .95 |
| Additions to Reserves: | | | |
| Service Benefit Reserves | 2.60 | 2.24 | .36 |
| Administrative Reserve | 4.99 | 3.72 | 1.27 |
| Investment Reserve | .81 | .42 | .39 |
| | $ 100.00 | $ 100.00 | $ |

Doctor Dessloch, presiding, stated that the next matter before the Council was the subject of Major Illness Expense Insurance (catastrophe protection) and asked that the secretary explain the subject. Mr. Crownhart referred to the following special report of the Executive Commiteee of the Commission:

## SPECIAL REPORT ON CATASTROPHIC ILLNESS INSURANCE
### May, 1954

This report asks Council authority to proceed with the public offering of so-called catastrophic or major expense surgical-medical and ancillary insurance.

WHY the Commission feels this immediately advisable arises out of a combination of circumstances. Within the past three years a number of organizations have entered the field, and within the past several months two large insurance companies in Wisconsin have announced their own programs.

Many companies predicate its availability *only if all basic insurance* is also purchased of them.

Thus, to the extent Wisconsin installations of WPS become interested in this form of insurance, WPS stands to lose its basic program if it is not in a position to offer this form of extended coverage. By offering a catastrophic contract, WPS will, in a sense, be "protecting" its outstanding contracts.

There are other reasons. As many groups have achieved their aims in securing surgical-medical and hospital basic coverage, time loss, life, and accidental death and dismemberment coverage, it is natural that they turn to the field of medical expense often unfairly dramatized and oversimplified in connection with the so-called "dread diseases."

Catastrophic insurance has grown markedly within a year. More than a million policies were said to be in effect at the end of 1953.

It cannot be overemphasized that catastrophic insurance, in its genuinely comprehensive form, is far more complicated than the familiar basic surgical-medical policy now issued by WPS. Catastrophic insurance is still in the experimental stage.

For example, the average WPS claim today involves about $50 and cannot exceed $700. A catastrophic claim, on the other hand, will probably average well over $1,000, and the contract limits per person are $5,000 and per family $15,000. The management of these contracts is correspondingly much more complex.

One of the features distinguishing catastrophic coverage from the basic surgical-medical coverage written by WPS is the deductible amount, such as the first $500 of charges per illness, and coinsurance, such as 20 per cent, assumed by the patient on the excess of his catastrophic expenses over $500. It is not contemplated that coinsurance apply to the rea-

sonable charges made by *participating* physicians. Their charges will be paid in full.

The chief reasons for a deductible amount and a percentage sharing of the excess costs over such amount are, first, to bring the insured person into the management and control of the costs of his own case and, second, to reduce the high premium. This control device is followed in all catastrophic insurance thus far written, so far as we can determine.

We learned, within the week, that Medical Indemnity of America, the national Blue Shield insurance company, is planning to enter the catastrophic field but is waiting to learn what local Blue Shield plans, including WPS, are doing.

There are those who believe that catastrophic insurance will modify basic coverage such as WPS issues today. It may encourage a coinsurance feature in such basic coverage, thereby reducing its cost. The availability of catastrophic insurance may in some degree reduce the need and the demand for the much more limited basic contract now issued. All this remains to be shown in the future.

DOES THE SOCIETY HAVE ANY BUSINESS ENTERING this field of insurance for reasons other than the protection of its basic program?

It does if it can offer something not only constructive and in the public interest, but also something that only it can do. Full payment is available only through the mechanisms of the medical profession and is the fundamental reason for Blue Shield of Wisconsin.

This same concept can be made available in the major medical expense field by the enrollment of participating physicians who will agree with their own Society that benefits paid for their services will be accepted in full payment and that their charges will be reasonable and proper to the case.

BUT WHAT ABOUT THE PHYSICIAN WHO DOES NOT PARTICIPATE, for he can make charges according to his own practice?

The solution proposed arises out of an actuarial fact of life. Major expense illnesses are not subject to the scheduling of benefits as are short-term conditions. One polio case may involve much more care than another. The actual test of what is reasonable falls more in the field of what might be termed a *reasonable range.*

Since the whole thesis of the basic Blue Shield program is *full payment* within specified *income limits*, it must be assumed that the benefits available as full payment under the "A" and "B" schedules represent *reasonable charges* to persons under the "A" and "B" income levels. This philosophy is as fundamental to catastrophic coverage as it is to the basic program, and this is the only premise which will preserve the support of the participating physician.

The non-participating physician in both the major medical expense and basic fields is *non-participating because he wants to be free to charge more,* at least in some cases, than the plan provides.

Therefore, it follows that if Blue Shield is to treat the non-participant under catastrophic in exactly the same dollar way that it treats the participant, Blue Shield will actually be paying out more dollars to this group.

This actuarial fact of life may price the major medical expense out of the picture because so many charges will tend to be at the top limits of "reasonable" rather than near or under the middle range.

THEREFORE, THE COMMISSION PROPOSES THAT WHERE SERVICES ARE PERFORMED BY A NON-PARTICIPATING PHYSICIAN, the plan will pay 80 per cent of reasonable charges as against 100 per cent of the reasonable charges of the participating physician.

If, however, the purchaser wants the same protection for the non-participating physician's bill as he does for that of the participating physician, it will probably ultimately, although not initially, be available at additional cost.

An added factor strongly influenced the Commission to this recommendation. Blue Shield of Wisconsin is calculating its contract provisions and its rates based upon Wisconsin experience and its experience with the participating physician.

Without controls of the character outlined, those covered under major medical expense would be under no influence to obtain their needed care in Wisconsin. If the insured feels free to purchase that care any place in the country, what we in Wisconsin hold to be reasonable and fair within the particular circumstances in our state may in some areas be considered too low and not within the customary practices of the medical community.

The Commission does not criticize those variations. They exist in many other fields as well. The rates charged Wisconsin physicians for liability insurance are less than those charged on the West Coast and perhaps more than those charged elsewhere.

But this is a Wisconsin plan, of Wisconsin doctors, for Wisconsin citizens. It should be operated as such.

The secretary stated that the above report required Council action and pointed out that in its annual report to the Council, which was forwarded to the House of Delegates in the fall of 1953, the Commission on Prepaid Plans had made known its general recommendations as to this type of insurance and the time table which had been developed in that connection. This report had received favorable action at that time, and one statement in it was specifically to the effect that Council approval would be sought at the appropriate time.

Secretary Crownhart stated that an associated question arose out of the special staff report to the Executive Committee of the Commission which had been prepared May 12 (and was submitted to the Committee at the time of a special meeting held May 13) as follows:

## CATASTROPHE INSURANCE—STAFF REPORT TO THE EXECUTIVE COMMITTEE

May 12, 1954

In 1951 and 1952, WPS, appreciating trends in this field, began the building of a file of resource material and directed some of that material to the attention of Society members responsible for operation of the prepaid plans.

In early January 1953, Blue Cross urged WPS to prepare a catastrophic contract and reported that Blue Shield and Blue Cross should enter the field.

On April 1, 1953, Mr. Wheeler, Executive Vice-President of Blue Cross, was informed of March 1953 Commission action, including plans that benefits are to be available only after basic benefits of Blue Shield and Blue Cross or other insurance benefits have been exhausted. He was also told that the program was to be developed in cooperation with Blue Cross "in an endeavor to integrate Blue Cross in the program, dovetail coverages to the extent possible, and achieve uniformity of contract and administration."

In May 1953, WPS agreed to transmit, prior to the next staff meeting, the substance of its conclusions as to type of coverage, deductible features, etc.; and Blue Cross agreed to report to WPS so that, at the time of the next meeting, the staffs could endeavor to reconcile differences. Apparently, neither staff was able to prepare its material in advance; but the subject was taken up at the time of the next meeting in July 1953.

In June 1953 the Commission considered a staff report on studies to that time and directed that a further report be made at its next meeting.

In July 1953, in joint staff meeting with Blue Cross, the Blue Shield staff reported progress and developments to that date and stated that plans called for the project being completed so that contracts would be available for sale during the first six months of 1954. Blue Cross agreed to analyze the presentation further and to proceed with preparation of the hospitalization counterpart as soon as possible.

At the September 1953 meeting of the Commission, further report was made by the Blue Shield staff, which approved the general principles of the program developed to that point and instructed that a further report be made at the December meeting.

On September 15, 1953, the next joint staff meeting with Blue Cross, this development was reported by the secretary.

In December 1953 the Commission reviewed in detail a draft proposal concerning the catastrophic plan and referred the matter to the Executive Committee.

At the March 1954 meeting of the Commission, the seventh draft of the catastrophic contract was reviewed; and the Commission then committed the subject to the Executive Committee with authority to act and "to finally approve the contract for offering July 1."

In the last week of March 1954, developments were reported to Mr. Nauert of Blue Cross, with the suggestion that the matter be discussed by him with Mr. White of Carl Tiffany & Company at the time of the annual meeting of the Blue Shield plans in New York early in April. Mr. Nauert agreed and said that he would have Mr. Thompson, consulting actuary to Blue Cross, present.

On April 1, 1954, Mr. Nauert was furnished with the sections on definitions, benefits, and exclusions as taken from the seventh draft of the proposed contract.

Having heard nothing from Blue Cross subsequent to the forwarding of contract forms in March and April 1954 and because of the imminence of the meetings with the Executive Committee and the Council during the week of May 10, Mr. Crownhart wrote Blue Cross on April 26, stating that the subject of catastrophic insurance would be presented to the Council the week end of May 15 and that it "will be necessary, then, of course, to state the decision and essential contract provisions of Blue Cross in the same field." He asked that a special staff conference be arranged for May 10 or 11. It was held on May 11, 1954.

It became evident at that meeting that the Blue Cross staff and Mr. Thompson had done only the most general preliminary work in the field. They outlined the possibility of a hospital rider paying 75 per cent of the excess expenses of its present 70-day or 120-day contracts, after a corridor deductible. They felt that they covered hospital expenses adequately at present and that 79 per cent of their total contracts, including those in the Milwaukee County area, are the comprehensive, the 120-day or the cost-plus contracts. They stated that they thought the catastrophic field for hospital expenses was a very limited one.

It was also clear that Blue Cross had not developed underwriting rules, rates, or contract. Mr. Thompson at one point said that Blue Cross of Wisconsin had "to put first things first," referring to the problems facing Blue Cross during the balance of 1954 as their substantial rate changes take effect.

Mr. Thompson's statements, in which the Blue Cross staff seemed to concur, may be summarized as follows:

(a) Blue Cross doubts that there is any necessity of offering a catastrophic program immediately, feeling that the present demand for it is one created by commercial companies or by physicians who are trying to broaden the area of their practice covered by insurance.

(b) Blue Cross must proceed very slowly with catastrophic at this time because it is absorbed in working out its other problems and should not undertake the many unknowns of catastrophic coverage until it has completed the rate changeover which was effective May 1, 1954.

(c) The catastrophic program must not be offered under circumstances which would upset the "delicate

Blue Cross relationships" with groups now being written. That is particularly true during this period of changeover to the new rate structure, which will require at least the balance of 1954.

(d) The public wishes and buys the more complete, rather than the more limited, coverage. The public has not accepted the coinsurance contract of Blue Cross or any other limitations on comprehensive coverage. Blue Cross representatives expressed no interest in offering a basic contract with coinsurance feature supplemented by a catastrophic rider, although urged by the WPS staff.

(e) Blue Cross would like to defer further consideration until January 1955, although it might be able to make a rider available to a group which specifically required it as a condition of remaining in the Blue Cross–Blue Shield program. It would probably be only the 70-day contract to which such a rider would be added.

(f) Blue Cross and Blue Shield catastrophic policies, when offered, should be sold as a package.

(g) In response to a question, Mr. Thompson stated that an independent WPS sales staff is highly undesirable, represents a fundamental departure from previously established Blue Cross–Blue Shield relationships, could cause confusion, and cannot well be offered independently of the basic programs.

(h) If Blue Cross acts as agent of WPS in the sale and billing of catastrophic policies, its agency costs should be *much lower* than its cost of selling and servicing the basic surgical-medical program.

(i) For an indefinite period, which impliedly, at least, might run three years, the only WPS groups which should be contacted should be those experience-rating groups which are entitled to a refund. To date, this limits WPS to only 30 of its more than 100 merit-rating groups. Any such sales policy would automatically exclude from consideration substantially 99 per cent of the roughly 3,000 groups now carrying WPS.

It must be obvious that Blue Cross and Blue Shield do have, at times, problems or considerations which are not common to both, although the problems of one may affect the other.

Blue Shield does not question the right of Blue Cross to decide what it will and will not make available by way of sales staff and other implementation of some new Society program.

In this instance, Blue Shield feels that catastrophic insurance must be within its portfolio and its availability generally known. It is the logical next step in the maturing of the WPS program. It should be offered without further delay so that experience can be gathered in Wisconsin and the program made increasingly available to the public. The larger commercial companies are already writing catastrophic policies. Ten Blue Shield plans have entered the field during the past three years. Further, it is recognized by Blue Shield that there must be sufficient installations to assure a spread of risk and make the plan self-financing administratively.

Blue Cross possesses the only sales staff now available. The recent staff conference is again strongly indicative that Blue Cross administrative and sales policies, developed out of their own problems, will be superimposed over Blue Shield wishes where the two may be in conflict.

However, where Blue Cross does not wish to or cannot meet the needs of Blue Shield, the next question is whether Blue Shield wishes to do for itself what its agent finds it impossible to do. Further examples of the problem are furnished by the lack of success, or even evidence of effort, on the part of Blue Cross to sell many of the several riders made available by WPS almost a year ago in order to improve coverage available to the public.

In light of the considerations above summarized, it is the unanimous recommendation of the WPS staff and consultants that:

(1) WPS engage in a direct selling program of its catastrophic contract beginning July 1, 1954.

(2) A hospital rider be developed for use with the catastrophic illness policy under which WPS will pay 80 per cent of hospital expenses for major illness charges under the following conditions:

(a) The benefits paid must represent hospital charges in excess of those incurred for a specified number of hospital days or a specified deductible amount, such as $300, whichever figure is greater.
(b) The benefits for a private room shall not exceed $____ per day.
(c) Charges made by a hospital must be for services deemed necessary by the attending physician.

(3) Because of the newness of catastrophic insurance and the frankly experimental nature of the WPS program, the Commission make a continuing review of the business written and a careful evaluation of the data yielded by its experience with these policies.

(4) A budget be established for the independent selling of the program. Because of the specialized character of this insurance and the extensive amount of travel involved, it is estimated that the combined remuneration and travel expenses of a sales staff would average $12,000 per man annually.

(5) Blue Cross be advised promptly of the decicions relating to the above which may be made by the Executive Committee and the Council at their May 1954 meetings.

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Secretary Crownhart then stated that the Executive Committee, after a long session in review of the problem presented by the fact (1) that July 1 had been announced as the availability date of the new program, (2) that this fact had been known to Blue Cross for many months, and (3) that a contract in this field without some type of benefit for

hospital costs would be but half a package, had taken the following action which was now recommended to the Council for approval:

> The Executive Committee recommended to the Council that the staff be empowered and ordered to make all the necessary arrangements to have a full-package catastrophic coverage available by July 1 or as soon as practical thereafter.

The Executive Committee further adopted a motion as follows:

> It is recommended that the staff hold itself open to any reasonable offer from Blue Cross which assures an appropriate hospital rider, reasonable enrollment requirements, and adequate staff to implement the program.

Acting Chairman Dessloch asked that the secretary discuss the special staff report which had been accepted and upon which action had been taken by the Executive Committee for Council review.

Mr. Crownhart stated that in the history of association of Blue Shield with Blue Cross, there had been occasions when decisions of Blue Shield had, in effect, been vetoed by Blue Cross. As an example, he pointed to the occasion when the new program embodied in the "A" and "B" Schedules had been finally determined upon by the House of Delegates and a time table to execute it had been determined by the Commission on Prepaid Plans in meetings in which Blue Cross representatives had been present. Following those decisions, however, and at the very last moment, Blue Cross had advised that it was not ready to proceed with installation of the program. He pointed out that Blue Shield had insisted, and had succeeded in its insistence, that the changeover be made as directed by Commission action. He said that it was not until some months later that a possible reason for the Blue Cross position became apparent; namely, that it did not wish to contact groups and others for a changeover in the Blue Shield program at an increased cost, when Blue Cross knew that at a later but early date, it would be required to increase its own rates and thus would have to go back to groups in which a Blue Shield changeover had been effected and sell those groups on a Blue Cross increase.

Now, he said, after many months of developing the program of major illness expense coverage, Blue Cross, with little or no notice, yet knowing the plans and the work of Blue Shield, indicates such strict limitations upon announcement and contacts that it amounts to superimposing its own judgment as final. Consequently, Mr. Crownhart said, he felt that the time had come when a very fundamental decision must be made by the State Medical Society. If the Society, through its various mechanisms, were to engage in various studies and projects only to find them subject to final action by Blue Cross, then Blue Shield would not be in fact a "doctors' plan," and the responsibility for its administration and control would be really that of Blue Cross. He said that if that situation were to be accepted, he felt it would be better that the complete responsibility for the management of Blue Shield be placed in the hands of Blue Cross. Mr. Crownhart said that it was certainly within the rights of an agent to determine what it would and would not sell, except as to those contracts which it had agreed to sell.

Mr. Crownhart said that in the field of major illness expense coverage the Blue Cross portion was relatively unimportant, and no agency relationship exists between Blue Shield and Blue Cross as to it. The overwhelming majority of the rates charged for the entire package would be required for the medical and associated services rendered subscribers, for under the Blue Cross comprehensive program perhaps as much as 95 or 96 per cent of the duration of hospitalization was included. Therefore, it followed that a Blue Cross companion package in the hospitalization field would affect a very minor percentage so far as duration was concerned.

Mr. Crownhart went on to say, in substance, that this problem presented very squarely the alternative of implementing the Blue Shield program through its own staff when Blue Cross was unable to provide the necessary implementation itself.

He also stated that in the planning of the Blue Shield major illness expense coverage it was not intended in any way to come into any conflict with the other Blue Shield plan in the state, but he felt that the situation now disclosed was of such significance that liaison between the two plans should be perfected. He said that, while each plan might have need for varying contracts and benefits, nevertheless, the philosophies of both are identical in the interest of subscriber and physician alike and that this liaison is necessary under the principle that in union there is strength.

Doctor Dessloch commented upon the report and stated that, while there was uncertainty as to whether Blue Cross would be prepared with a satisfactory companion program by July 1, and with a sales force satisfactory for the purpose of the two plans, nevertheless, it now appeared that the Commission on Prepaid Plans needed the authority to proceed as of that date in event Blue Cross was not ready on either basis.

After discussion participated in by Doctors Wegmann, Stovall, Galasinski, Fons, Bernhart, Witte, Kasten, and Casper a motion earlier stated by Doctors Casper–Ekblad that the Council grant Blue Shield the authority to proceed with catastrophic insurance for marketing on July 1, 1954, and, further, that it impose on the Commission on Prepaid Plans the obligation to study and put into effect a reinsurance program, was put to a vote and unanimously carried.

Following such action, and on motion of Doctors Galasinski–Ekblad, carried, the following motion was adopted:

> That there be a joint meeting of the Commission on Prepaid Plans and the Operating Committee of Surgical Care of Milwaukee County.

13. June AMA Meeting

As is customary at the Council meeting preceding the American Medical Association meeting, there was discussion of matters which it was felt might be brought before the national meeting. The secretary stated that it was too early to determine the major problems to be presented but that there would undoubtedly be discussion of current legislative activities of the present administration. There was discussion of the proposed government reinsurance corporation and of a Department of Defense proposal for medical care of the dependents of men in military service. It was pointed out that other legislation involves expansion of the Hill–Burton Act to include nursing homes and rehabilitation centers; reorganization of public health grants; and vocational rehabilitation.

Other matters brought to the attention of the Council for expression of its opinion to the Wisconsin AMA delegation included one state's resolution requesting the Joint Commission on Accreditation of Hospitals to abolish the requirement of compulsory staff meeting attendance, recommendations of an *ad hoc* committee of the AMA regarding intern training and internship approval, the national blood program, and a report on osteopathy.

After considerable discussion of these matters and on motion of Doctors Kasten–Zellmer, carried, the Council extended full discretion to the AMA delegates and issued no instructions.

14. Dr. R. E. Garrison

Dr. R. E. Garrison, councilor from Wisconsin Rapids, was given a rising vote of thanks and appreciation for his hospitality and that of his associates.

15. Adjournment

There being no further business, the Council adjourned its meeting at 12:20 p.m., Sunday, May 16, 1954.

C. H. Crownhart,
*Secretary*

Approved:
R. G. Arveson, M. D.,
*Chairman of the Council*

## Clinical Conference on
## MEDICAL ASPECTS OF MENTAL DEFICIENCY
### Northern Colony, Chippewa Falls, Tuesday, November 2, 1954

1:30 p.m.: Registration and Briefing of Cases To Be Studied
Supt. J. Howard Murphy and Leslie A. Osborn, M. D.

2:00 p.m.: Stationary Clinic: With Patients
Case studies of hydrocephalics, cretins, and other types of ambulatory patients
Doctors Smith, Kelley, Davis, Lorenze, Osborn, and staff of Northern Colony
Bedside Clinic: With Patients
Other types of non-ambulatory cases will be discussed at the bedside.

4:15 p.m.: Tour of the Grounds and Facilities

5:15 p.m.: Social Hour: At home of J. Howard Murphy, Superintendent

6:30 p.m.: Dinner (provided by Wisconsin Department of Public Welfare and the State Medical Society)

8:00 p.m.: Meeting of the Chippewa County Medical Society (And all others who wish to remain)
"MEDICAL, FAMILY AND SOCIAL ASPECTS OF MENTAL DEFICIENCY"
Drs. Hans H. Reese and Leslie A. Osborn

IMPORTANT: Make your reservations by writing the State Medical Society, Box 1109, Madison, *indicating whether or not you will remain for dinner.*

*Facts about*

THE DOCTOR'S PLAN

THE BLUE SHIELD PLAN OF THE STATE MEDICAL SOCIETY OF WISCONSIN

# WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

## Blue Shield Here and There

Blue Shield Medical Care Plans, the national association of Blue Shield plans with headquarters in Chicago, periodically issues a bulletin on new developments in Blue Shield plans and the health insurance industry in general around the nation. Here are some items that might interest Wisconsin physicians:

**Indemnity Plans**—California Physicians Insurance Co., with capital of $400,000, was recently chartered and licensed to operate as a nonprofit subsidiary of California Physicians Service (CPS) to facilitate handling of national accounts on an indemnity basis. All stock in the new company is owned by CPS, the Blue Shield plan. Blue Shield in Wisconsin recently did the same by forming a plan known as Physicians Indemnity Plan . . . for the same purpose.

* * *

**AMA Appoints McCormick**—Newest member of the National Blue Shield Commission is AMA appointee, Edward J. McCormick, M. D., Toledo, immediate past president of the AMA. He will serve a term of three years. Already a member of the Commission is Louis H. Bauer, M. D., Hempstead, N. Y., also a past president of AMA.

* * *

**Blue Shield in South Dakota**—The Committee on Prepayment and Insurance and the Council of the South Dakota Medical Society recently met to discuss organization of a Blue Shield plan for that state. Preliminary surveys show that physicians favor such a proposal 5 to 1. Thirty-five per cent have volunteered to contribute initial funds.

* * *

**Service Benefits**—Nebraska Blue Shield (now 10 years old) is offering a contract with $5,500 income ceiling for families . . . medical society in Oklahoma recently appointed a committee to study service benefit (full-payment) program . . . is also being studied in Rockford, Ill. . . . Jefferson County Medical Society (Birmingham, Ala.) has approved $6,000 ceiling service benefit proposal originally intended for steel employees but likely now to be offered general public.

* * *

**Up in the Air**—Health insurance plans frequently find themselves "up in the air" for a variety of reasons. The Rockford Blue Shield Plan (Illinois) is now airborne literally. It has a Beechcraft Bonanza for speedy air travel and a licensed pilot on payroll in enrollment department.

* * *

**New Buildings**—Blue Shield and Blue Cross in Oklahoma recently dedicated a new building. . . . Kansas Blue Shield-Blue Cross moved into a new building a few weeks ago. . . . the Mississippi plan has been housed in a new office since August. . . . Michigan plan, ditto. . . . Arkansas plan, pouring foundation. . . . Kansas City plans have purchased ground for construction next year. . . . State Medical Society of Wisconsin's new building (housing Wisconsin Physicians Service offices) is growing rapidly, expected to be ready for occupancy next June.

* * *

**SAMA Essay Contest**—At least 25 Blue Shield plans in nation will sponsor Student AMA essay competition in their areas. . . . Blue Shield of Wisconsin included. Subject to be determined by national Blue Shield and SAMA officials.

* * *

**New Pamphlet**—Available soon for physicians and laymen is a new pamphlet published by Public Affairs Committee on "The Story of Blue Shield." Authored by Robert M. Cunningham, editor of "Modern Hospital," and sponsored by the Blue Shield Commission as a public relations project.

For information or advice

Write • 704 E. GORHAM ST., MADISON, WIS. Phone • 6-3101 MADISON, WIS.

# Society Proceedings

## Brown–Kewaunee–Door

A joint meeting of the dentists and physicians of Brown, Kewaunee, and Door counties was held on September 9 at Sturgeon Bay.

Preceding a buffet dinner arranged by *Dr. D. E. Dorchester*, the afternoon was spent in golfing, horseshoe, baseball, cards, cruising, and sailing.

Members of the society were invited to visit Parke, Davis Laboratories in Detroit on October 24, 25, and 26.

## Fond du Lac

The annual business meeting of the Fond du Lac County Medical Society was held at 7:00 p.m. on Thursday, September 23. The Fond du Lac Elks Club was the place of the meeting.

## Grant

The Grant County Medical Society met at the Golf Club in Lancaster on August 26. Golf was played from 4:00 to 6:00 p.m., and the Lancaster Commercial Club joined the group for dinner at 7:00.

Mr. Steve Gavin, Jr., State Medical Society legal counsel, Madison, gave a discussion on the "Code of Interprofessional Ethics." Dr. H. Kent Tenney, Jr., Madison, president of the State Medical Society, spoke on current activities of the Society.

## Kenosha

The Kenosha County Medical Society met in Kenosha on September 2 at Oage Thomsen's Restaurant. Forty-four members attended.

*Dr. Edwin G. Olmstead* of the Milwaukee County Hospital, Milwaukee, presented a discussion on the "Treatment of Refractory Heart Failure."

## Manitowoc

The Manitowoc County Medical Society met on September 23. *Dr. Edwin C. Albright*, assistant professor of medicine, University of Wisconsin Medical School, spoke on "Thyroid Disease."

## Outagamie and Winnebago

A joint meeting of the Outagamie and Winnebago County medical societies was held at the Kimberly–Clark Corporation's sales promotion center in Neenah on September 9.

A tour was made of Kimberly–Clark's Lakeview mill and was followed by dinner and a program, at which Dr. Edward Holmblad, managing director of the Industrial Medical Association, Chicago, was the speaker. He discussed some aspects of industrial medicine. A movie entitled "A Trip Around the Mills" closed the evening program.

## Pierce–St. Croix

The Pierce–St. Croix County Medical Society met August 17 at Jeatron's at Menomonie, with *Dr. P. A. Heiser* of Woodville as host.

A discussion on the treatment of acute head injuries was given by Dr. Robert L. Merrick, neurosurgeon of St. Paul, Minnesota. The address was followed by a question and answer session.

## Richland

At the regularly scheduled meeting of the Richland County Medical Society on September 2, held at *Dr. R. E. Housner's* cottage on the Wisconsin River, *Dr. L. J. Van Hecke* of Milwaukee was the guest speaker. His subject concerned "Medico-Legal Problems of Medicine."

Mr. Steve Gavin, Jr., legal counsel, and Mr. Roy Ragatz, assistant secretary of the State Medical Society, discussed legislation and quackery.

## Wood

The regular meeting of the Wood County Medical Society was held at the Hotel Charles, Marshfield, on August 12.

*Dr. R. P. Potter* of Marshfield was made a life member of the State Medical Society and a member of its 50 Year Club. Doctor Potter, along with five other physicians, founded the Marshfield Clinic in 1916; and he served as its president from 1934 to 1940.

## Tenth Councilor District

The Tenth District Clinical Conference was held in Eau Claire, Wisconsin, on September 16. The morning program was at Luther Hospital, Eau Claire, and the afternoon and evening program at Hillcrest Country Club.

Among the speakers were Dr. David G. Decker, Obstetrics and Gynecology Section, Mayo Clinic, who spoke on "Current Concepts of Therapy for Carcinoma of the Cervix;" *Dr. Ovid O. Meyer*, professor and chairman, Department of Medicine, University of Wisconsin Medical School, who discussed "Nephritis;" *Dr. John W. Harris*, professor and chairman, Department of Obstetrics and Gynecology, University of Wisconsin Medical School, "Some Common Gynecologic Mistakes;" Dr. O. T. Clagett, Surgical Section, Mayo Clinic, "The Surgical Management of Indeterminate Pulmonary Lesions."

The evening dinner hour was followed with talks by Dr. H. Kent Tenney, Jr., Madison, president of the State Society, and Mr. C. H. Crownhart, secretary, who spoke on "Current Trends in Medicine."

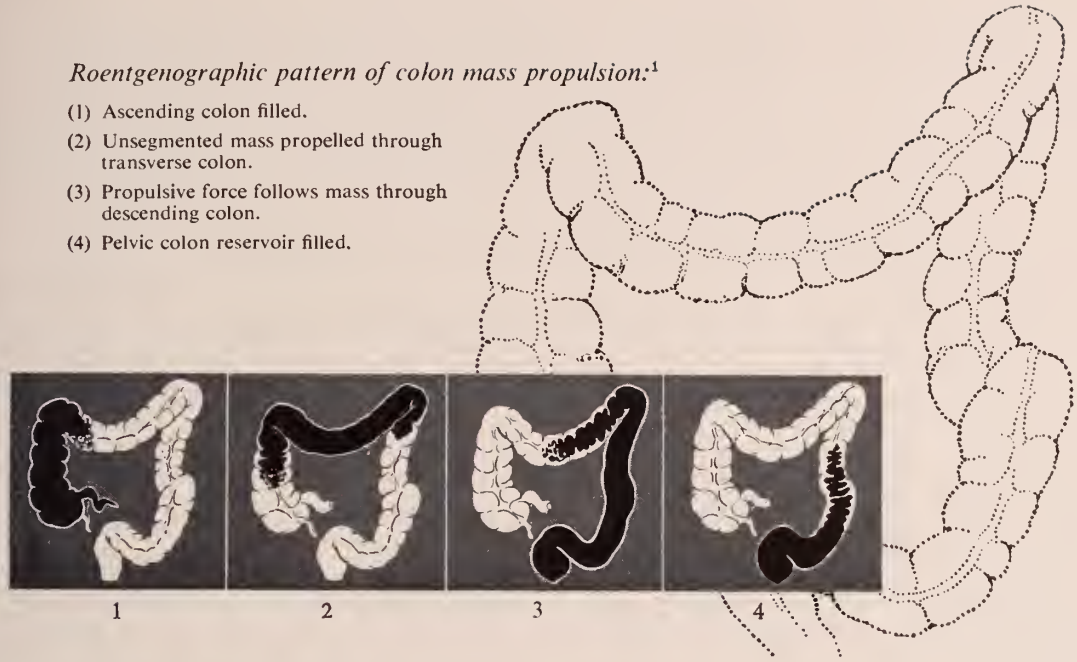
*Roentgenographic pattern of colon mass propulsion:*[1]

(1) Ascending colon filled.

(2) Unsegmented mass propelled through transverse colon.

(3) Propulsive force follows mass through descending colon.

(4) Pelvic colon reservoir filled.




# Reestablishing Bowel Reflexes with Metamucil®

*Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.*[2]

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of Plantago ovata) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

*Factors Contributing to Chronic Constipation*

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.[2]

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

*Dosage Considerations*

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice: A Text in Applied Physiology, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bargen, J. A.: A Method of Improving Function of the Bowel, Gastroenterology *13*:275 (Oct.) 1949.

# News Items and Personals

## St. Joseph's Hospital Staff at Dodgeville Holds Meeting

At a meeting on September 9 at St. Joseph's Hospital, Dodgeville, the staff heard the discussions by the following Madison physicians:

*Dr. S. B. Harper:* "The Use of ACTH and Cortisone with Particular Reference to its Indications and Contraindications in Surgery"

*Dr. E. J. Nordby:* "The Intra-Articular Use of Hydrocortone in Orthopedic Problems"

*Dr. F. D. Bernard:* "Injuries to the Soft and Bony Tissues about the Face."

## Doctor Stevens Attends World Medical Association Meeting

*Dr.* and Mrs. *George H. Stevens* of Wausau attended the meeting of the World Medical Association in Rome, Italy, from September 27 through October 1.

They left New York City on Pan American Airlines for flight to London, England, where, accompanied by others who planned to attend the Rome meeting, they began a tour of England, Holland, Belgium, Switzerland, and Paris and Nice, France.

After returning to the United States, they planned to visit their son, Dr. George E. Stevens, in Washington, D. C. before returning home.

## The Eigenbergers Visit Europe

*Dr.* and Mrs. *Friedrich Eigenberger*, Sheboygan, flew to Europe on August 25. Doctor Eigenberger attended sessions of the International Society for Cell Biology at the University of Leiden, Leiden, Netherlands. Following the meetings in that country, the couple went to Paris, France, where the doctor was present at the International Congress of Hematology.

Doctor Eigenberger is a pathologist at Sheboygan Memorial Hospital.

## Doctor Bargholtz Appointed to Committee

*Dr. William E. Bargholtz*, Ashland, has been named to represent Ashland County on the Pureair Sanatorium Committee.

Doctor Bargholtz is a 1931 graduate of the University of Iowa Medical College. He is currently a member of the State Society Committee on Cancer.

**Cook County Graduate School of Medicine**

INTENSIVE POSTGRADUATE COURSES

SURGERY—Surgical Technic, Two Weeks, October 11, November 8
Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, October 11
Surgical Anatomy & Clinical Surgery, Two Weeks, October 25
Surgery of Colon & Rectum, One Week, October 25
Breast & Thyroid Surgery, One Week, October 25
Thoracic Surgery, One Week, October 11
Esophageal Surgery, One Week, October 4
General Surgery, One Week or Two Weeks, October 4
Gallbladder Surgery, Ten Hours, October 25
Fractures & Traumatic Surgery, Two Weeks, October 25

GYNECOLOGY—Office & Operative Gynecology, Two Weeks, October 18
Vaginal Approach to Pelvic Surgery, One Week, Nov. 1

OBSTETRICS—General & Surgical Obstetrics, Two Weeks, November 1

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, October 11
Gastroenterology, Two Weeks, October 25
Gastroscopy, Two Weeks, November 8

RADIOLOGY—Diagnostic Course, Two Weeks, October 4
Clinical Uses of Radio Isotopes, Two Weeks, October 4

PEDIATRICS—Clinical Course, Two Weeks, by appointment
Congenital & Rheumatic Heart Disease in Infants & Children, One Week, October 11 and October 18
Two Weeks, October 11

DERMATOLOGY—Intensive Course, Two Weeks, October 18

CYSTOSCOPY—Ten-Day Practical Course, every two weeks

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## THIRD AND TWELFTH DISTRICTS NEWS

### Doctor Beno Moves to Indiana

*Dr. Thomas J. Beno,* formerly a resident at the Veterans Hospital, Wood, joined the surgical staff of the Muncie Clinic, Muncie, Indiana, on August 23, 1954.

Since graduation from the University of Wisconsin Medical School in 1946, he interned at St. Joseph's Hospital in Marshfield, completed a residency in surgery at the Veterans Administration Hospital, Wood, and was recently discharged from active military service in the U. S. Army. A year of his military service was spent in Korea as chief of the surgical service of the 14th Field Hospital.

Doctor Beno was certified by the American Board of Surgery in November 1953.

### Dr. Arnold Jackson Takes Over New Post

*Dr. Arnold S. Jackson,* Madison, began his term as president of the United States Section of the International College of Surgeons on September 7. He has served the International College as its secretary and program chairman for four years and as president-elect for the last two years.

### Academy of General Practice Rock County Chapter

Eighteen members of the Rock County Chapter, American Academy of General Practice, attended a meeting at the Monterey Hotel, Janesville, on August 18. *Dr. Paul Odland,* Janesville, discussed "Injuries of the Hand and Forearm."

*Dr. G. S. Metcalf,* Janesville, and *Dr. George H. Thomson,* Beloit, were elected delegates to the state meeting to be held in Milwaukee in November. *Dr. D. M. Clark,* Beloit, is president of the Rock County Chapter.

## SOCIETY RECORDS

**New Members**

P. M. Biason, Clinton.
W. S. Freeman, 407 Prospect Street, Beloit.
J. K. Trumbo,** Box 838, Wausau.
J. J. Brenner, 252 South Main Street, Adams.
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F. J. Glassy, 8700 West Wisconsin Avenue, Milwaukee.

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Leo Harkavy, Veterans Administration Hospital, Wood.

J. J. Roubik, Veterans Administration Hospital, Wood.

J. A. Alston, 1220 Dewey Avenue, Milwaukee.

P. T. Niland, 1204 Glenview Avenue, Milwaukee.

H. R. Foerster, Jr., 208 East Wisconsin Avenue, Milwaukee.

J. F. Becker, 333 East Huron Street, Chicago, Illinois.

J. L. Radai, 408 West Greenfield Avenue, Milwaukee.

W. A. Mudge, Jr., 6402 Sheridan Road, Kenosha.

M. D. Blackburn, Jr., 1007 South Van Buren, Green Bay.

Changes of Address

D. A. Smith, Milwaukee, to M. R. 26, Bechand Beach, Fond du Lac.

E. S. Huston,* Bremerton, Washington, to 901 High Street, Madison.

Margaret A. Schaefer, Aurora, Colorado, to 7180 Eastondale, North Long Beach, California.

J. W. Frye,* Colorado Springs, Colorado, to 208 Second Street, Merrill.

D. A. Cofrin,* Enid, Oklahoma, to 1415 N. W. 15th, Oklahoma City, Oklahoma.

R. A. Flynn, Columbus, Georgia, to Sparta Clinic, Sparta.

R. F. Braun, Winnebago, to 90 McKinley Avenue, Clintonville.

Edna M. J. Fitch, Madison, to 3811 O'Hara Street, Pittsburgh, Pennsylvania.

C. W. Crawford, Madison, to 1288 South Oneida Street, Green Bay.

G. E. Bryant, Menomonie, to 11436 Chester Road, Cleveland, Ohio.

J. A. Tasche, Sheboygan, to 730 Freeling Avenue, Siesta Key, Saratosa, Florida.

Milton J. Fox, Rantoul, Illinois, to 7935 West Eagle Street, Milwaukee.

P. D. Nelson,* Bethesda, Maryland, to Marine Corps Schools, Quantico, Virginia.

N. J. Kozokoff,* A.P.O., San Francisco, California, to 123 Upland Avenue, Youngstown, Ohio.

H. R. Duffy,* A.P.O., San Francisco, California, to Air Imf. Pac., M.C.A.S., El Toro, California.

J. D. Teigland, Milwaukee, to 505 Bankers Trust Building, Des Moines, Iowa.

G. E. Fox, Forest City, Iowa, to 313 North Fremont Street, Stevens Point.

G. J. Bordenave,* Milwaukee, to M.F.S.S. Brook Army Medical Center, Fort Sam Houston, Texas.

E. F. McNichols, Milwaukee, to Amonate, Virginia.

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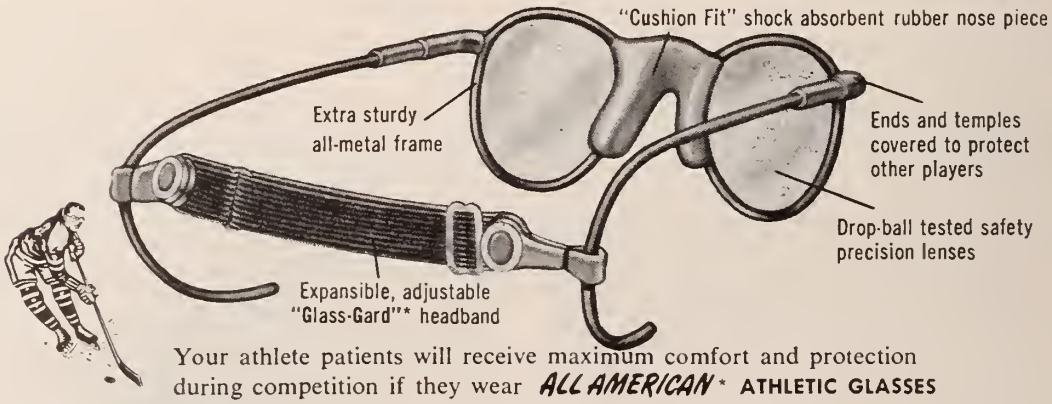


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1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America 30:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice. New York, Springer Publishing Company, Inc., 1953, p. 225.

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## DEATHS

H. H. CHRISTOFFERSON

**Dr. Henry Herbert Christofferson,** Colby, expired at his home on September 1 at the age of 79 years.

He was born at Lynn Center on March 27, 1875. Graduating from St. Louis University School of Medicine in 1902, he practiced at Loyal for nine years before moving to Colby in 1911. He served that community until his retirement in 1946; and since the establishment of the Clark County Hospital at Owen in 1922, he had been its physician, showing an active interest in problems of the mentally and chronically ill and the aged.

Well known as the "father of the Wisconsin Plan," he was chairman of the Committee on Extension of Insurance of the State Society in 1944–5, studying prepaid health care programs and the need for them. In October 1945, he introduced the resolution before the House of Delegates of the State Society which resulted in the adoption of the Wisconsin Plan of Prepaid Health Care.

He also had urged the development of a loan fund for needy medical students which resulted in the establishment of the Student Loan Fund of the State Medical Society in 1950.

Doctor Christofferson had served as councilor for the Ninth Councilor District from 1939 to 1950 and became president of the State Medical Society in October 1950. For many years he was chairman of the State Society's Committee on Mental Hygiene, Institutional Care, Public Welfare, and State Departments. In 1938 he was a member of the Special Committee to Study the Distribution of Health Services and Sickness Care. He had also been a member of the American Medical Association's Committee for Evaluation of Foreign Schools.

He had been a member of the State Board of Medical Examiners from 1937 to 1953 and had served as its president.

He was a member of the Clark County Medical Society, a life member of the State Medical Society of Wisconsin, and a member of the American Medical Association.

His wife, Fredricka, preceded him in death in 1952. One brother, Dr. A. M. Christofferson of Waupaca, survives.

**Dr. Frederick E. Tryon,** Baraboo, died on August 9 at the age of 77 years.

He was born on October 8, 1876, in New York State. He attended the Southwest School of Medicine in Kansas City, Missouri, from which he graduated in 1910. His internship was served at the Metropolitan Hospital in New York City.

Prior to his 40 years of practice in Baraboo, he practiced at Merrimac. In Baraboo, he served the community as health officer.

Doctor Tryon was a member of the Sauk County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Mrs. Tryon is his only immediate survivor.

**Dr. Leo George Scheurich,** Tomah, died on August 11 at the age of 71.

Born in Neunkirchen, Bavaria, Germany, on December 8, 1882, Doctor Scheurich came to this country with his parents when he was 3 years old. The family settled in Baltimore, Maryland. In 1903, he entered the University of Maryland School of Medicine, from which he graduated in 1908. He came to Tomah in 1910 after serving two years in Bay View Hospital in Baltimore.

He was a member of the Monroe County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Margaret; three sons, Attorney Gregory Scheurich of Chicago and John and Leo, Jr., of Tomah; three daughters, Catherine (Mrs. John Wehnitz) and Jane, of Tomah, and Dr. Mary Scheurich of La Crosse; and six brothers, Dr. John, Louis, Eugene, Edmund, and Joseph of Baltimore, and Father Francis Anthony Scheurich of Tryon, North Carolina.

**Dr. Arthur G. Benson,** La Crosse, died on August 16 at the age of 73 years.

Doctor Benson was born on November 19, 1880. He graduated in 1913 from Marquette University School of Medicine and served his internship at Deaconess Hospital, Minneapolis, Minnesota. Prior to moving to La Crosse in 1938, he practiced at Rice Lake for 17 years.

Survivors include his widow, Lutheria; a daughter, Mrs. Kenneth Westburg; and a son, Dr. James Benson, who resides in Indiana. Another son, Paul, preceded him in death.

**Dr. Elgie Kraut,** Lancaster, expired August 17 at the age of 70.

He was born on May 18, 1884, at North Andover. After graduation from the University of Illinois College of Medicine in 1909, he set up practice in Beetown. Seven years later he moved to Lancaster, where he practiced until six months ago.

Doctor Kraut was a member of the Grant County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Elsie; two daughters, Mrs. Ivanelle Alt and Mrs. Russell Heath, the latter of Greenville, Ohio; and one sister, Mrs. Al Kartman, Beetown.

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**Dr. Frank W. Mackoy**, Milwaukee, passed away on August 17 at the age of 74.

Doctor Mackoy was born in Siloam, Kentucky, on November 24, 1879. He graduated from the University of Illinois College of Medicine in 1905 and did postgraduate work at the University of Michigan Medical School at Ann Arbor.

He served in the army from 1917 to 1918. Before he went to Sacred Heart Sanitarium, where he was in charge of the x-ray department for the last 37 years, he was assistant medical director of Mudlavia Sanitarium at Kramer, Indiana.

Doctor Mackoy was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, the Milwaukee Academy of Medicine, the Milwaukee Roentgen Ray Society, the National Gastroenterological Association, and the Radiological Society of North America, Inc. He was a Fellow of the American College of Radiology and was certified by the American Board of Radiology.

He is survived by his widow, Marjorie; a son, Richard, Beloit; a daughter, Mrs. Mary Louise Ebert, Honolulu, Hawaii; and a brother, Dr. Morris, Ann Arbor, Michigan.

**Dr. Henry M. Holtz**, Beaver Dam physician, passed away on August 19. Born in Portland on January 31, 1871, he was 83 years of age at the time of his death.

Doctor Holtz graduated from Hahnemann Medical College in Chicago in 1897 and also received a degree from Rush Medical College, Chicago, in 1898.

He was a former member of the Dodge County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He served as city physician in 1904. At the time of his death, he was president of the Wisconsin State Homeopathic Society.

Doctor Holtz's widow, Catherine, survives him.

**Dr. Charles S. Schneider**, Milwaukee, died at the Veterans Hospital, Milwaukee, on August 22, at the age of 56.

Doctor Schneider was born in Milwaukee in 1898, received his medical degree from Marquette University School of Medicine in 1926, and interned at Mount Sinai Hospital, Milwaukee. He began his general practice in 1927. In 1942 he entered the Army Air Force, serving overseas in the Aleutian Islands. He returned to his practice in 1945 and specialized in ophthalmology.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Genevieve; two daughters, Miss Maxine and Miss Judith Schneider, Milwaukee; a brother, Robert S., Minneapolis, Minnesota; and three sisters, Mrs. Rose Fryer and Mrs. Bertha Galin, Milwaukee, and Mrs. Nellie Levy, Los Angeles, California.

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**Dr. Gustav A. Hipke,** Milwaukee physician, died on August 24. Born on April 25, 1867, in Manitowoc County, he was 87 years of age at the time of his death.

He attended the Chicago College of Physicians and Surgeons, being graduated in 1890. He practiced in Allentown, Kewaskum, and Casco and, before moving to Milwaukee in 1899, took postgraduate work in obstetrics and gynecology in Berlin, Vienna, and London. He was professor of obstetrics and gynecology at the old Wisconsin College of Physicians and Surgeons in the period around 1905 and taught obstetrics in the Marquette University School of Medicine and, with his wife, founded the former Milwaukee Maternity Hospital and free dispensary. Approximately $20,000 which remained after the closing of the Milwaukee Maternity Hospital was given to the medical library operated jointly by the Milwaukee Academy of Medicine and Marquette University. The income from this fund was to be used for the purchase of books dealing with obstetrics and gynecology.

Doctor Hipke was a member of the Medical Society of Milwaukee County, a life member of the State Medical Society of Wisconsin, a member of the American Medical Association, and a charter member of the Endocrine Society and the newly formed Academy of Obstetrics and Gynecology.

Surviving are two sons, Dr. L. W. Hipke and Dr. M. M. Hipke, both of whom were associated with their father, and two brothers, A. S. Hipke, Chilton, and A. T. Hipke, New Holstein.

**Dr. Donne F. Gosin,** Green Bay physician, died at a Minneapolis hospital on August 25 at the age of 70 years.

He was born at Walhain on May 31, 1884. After graduating from Kewaunee High School, he taught in Kewaunee County for five years and then enrolled at Northwestern University Medical School, Chicago, from which he was graduated in 1910. He served with a surgical unit in France during World War I.

A member of the Brown–Kewaunee–Door County Medical Society, he served as its president in 1919. He was also a member of the State Medical Society of Wisconsin and the American Medical Association and was on the staff of St. Vincent Hospital.

Doctor Gosin had practiced medicine in Green Bay since 1929, when he joined his brother. Together they formed the Gosin Clinic.

Besides his widow, Mary, he is survived by two sons, Donne F. Gosin, Jr., of Upper Montclair, N. J., and John D. Gosin of Roslyn Heights, Long Island, N. Y.; a daughter, Mrs. Carl Witteborg, Jr., Green Bay; a brother, Dr. Fabian Gosin; and two sisters, Mrs. Eugene Messier and Mrs. Clara Gauthier, both of Green Bay.

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Lloyd F. Jenk, M. D.
Earl H. Ninow, M. D.
Paul J. Lawler, M. D.

**Dr. William R. Whitelaw,** Lodi, expired on August 26. At the time of his death, he was 101 years of age.

He was born at Caledonia on April 10, 1853. He was graduated from the University of Michigan at Ann Arbor. In 1880 he began his practice in Lodi.

Survivors include his daughters, Mrs. T. T. Wing, St. Paul, Minnesota, and Mrs. Anna Loper, Lodi; a son, Robert, of Madison; and a brother, Robert, of Santa Paula, California.

**Dr. Arthur G. Sullivan,** 69-year-old Madison physician, died on August 30 at a Madison hospital.

He was born on February 27, 1885, in Eau Claire. He was graduated from Columbia College of Physicians and Surgeons, New York, in 1909 and entered practice in Madison in June of that year. He was on the staff of Madison General and St. Mary's hospitals in Madison, St. Joseph's Hospital in Dodgeville, and St. Mary's Ringling Hospital in Baraboo.

Doctor Sullivan served as managing editor of *Postgraduate Medicine*, the journal of the Interstate Postgraduate Medical Association. He was a trustee of that association for 30 years and had served as its exhibit manager and managing director for 13 years.

He was an active member of the State Medical Society of Wisconsin and in the past served on many of its committees. In 1939 he was president of the Dane County Medical Society. He was also a member of the American Medical Association and a Fellow of the American College of Surgeons.

Surviving are his widow, Florence; a son, Arthur, of Horicon; a daughter, Mrs. John C. Waters, Orlando, Florida; a brother, Dr. Eugene Sullivan, Madison; and a sister, Mrs. Edwin Larkin, Eau Claire.

**Dr. Stephen E. Williams,** 76-year-old Chippewa Falls physician, died at his home on August 27.

He was born on June 15, 1878, at Whitewater, Wisconsin. After two years of premedical work at the University of Wisconsin, he attended the University of Minnesota, where in 1904 he received his medical degree. He interned at St. Joseph's Hospital in St. Paul during 1904–1905 and in 1905 entered general practice in St. Paul.

During the summer of 1907, he went to Europe and attended clinics in Ireland, Scotland, Wales, England, and France and later that year settled in

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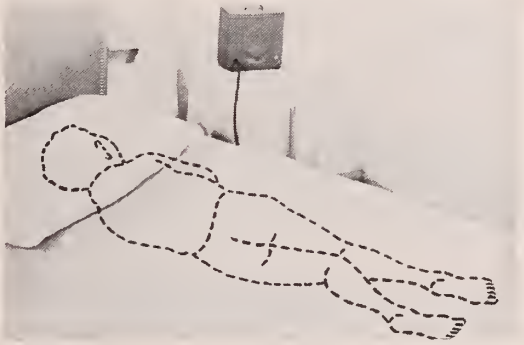

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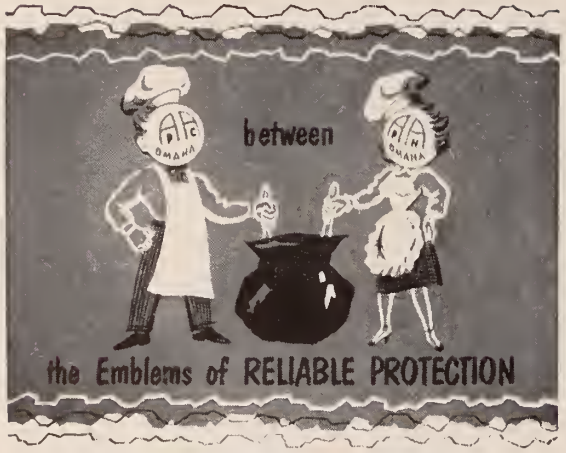


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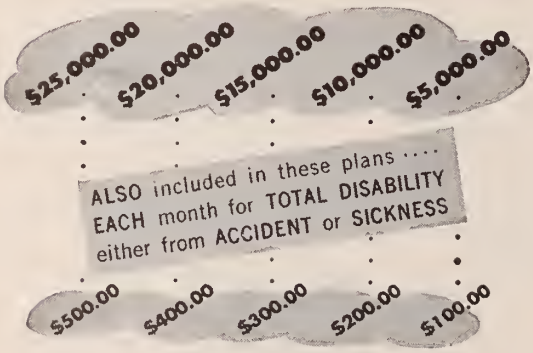


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Chippewa Falls, where he continued his practice until his retirement a few years ago. At his suggestion, in 1912 an old people's home, the Rutledge Home, was built in Chippewa Falls.

In 1925, Doctor Williams took the first postgraduate medical tour with the Tri-State Medical Society. Under the leadership of Dr. Charles Mayo, the tour included visits to clinics in Canada, Scotland, Ireland, Wales, England, and France.

In addition to serving as a general physician and surgeon during his medical practice in Chippewa Falls, Doctor Williams served his country as a first lieutenant in World War I. He was a member of the Mayo Clinic Surgeons Club, Chippewa County Medical Society, State Medical Society of Wisconsin, American Medical Association, and the International College of Surgeons and was a trustee of the Interstate Postgraduate Medical Association of North America. He was chief surgeon for the Northern Colony and Training School.

Doctor Williams was made a member of the Fifty Year Club of the State Medical Society of Wisconsin in 1954. He was recently honored by the Chippewa County Medical Society, which commemorated his 50th year in the medical profession.

Surviving are his widow; four sons, Colin of Chippewa Falls, Dr. Lowell, dentist, of Bloomer, Dr. Bruce and Stephen of Duluth; and one sister, Mrs. G. W. Swartz of River Falls.

**Dr. Edward T. Rathert**, Chilton, died at his home on September 1 at the age of 82 years.

Doctor Rathert was born in Brothertown on September 17, 1871. After graduating from Oshkosh State Normal School, he taught at Calumet and Fond du Lac County grade schools. He then entered Rush Medical College, Chicago, and graduated from there in 1900. He practiced medicine in Tigerton before moving to Chilton in 1912. For almost 40 years he served the city of Chilton as health commissioner and also served for several terms as Calumet County coroner.

In 1950, Doctor Rathert was made a member of the Fifty Year Club of the State Medical Society of Wisconsin. He was a member of the Calumet County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Besides his widow, Marianne, he is survived by four children, Charles Rathert, Mayville; Dr. Burton Rathert, Crandon; Mrs. Ruth Heinze, Ferndale, California; and Mrs. Marie Kuecherer of Delafield, and two sisters, Mrs. Minnie Salter, Chilton, and Mrs. Emma Stephan, Plymouth.

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All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal "Bookshelf,"* are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry, and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

**Handbook of Orthopaedic Surgery.** By Alfred Rives Shands, Jr., B. A., M. D., medical director of the Alfred I. DuPont Institute of the Nemours Foundation, Wilmington, Delaware, visiting professor of orthopaedic surgery, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania; and Richard Beverly Raney, B. A., M. D., professor of surgery in orthopaedic surgery, University of North Carolina, Chapel Hill, North Carolina, lecturer in orthopaedics, Duke University School of Medicine, Durham, North Carolina. Fourth edition. St. Louis, The C. V. Mosby Company, 1952. Price $8.00.

This book, now in its fourth edition, presents in concise form the principles of orthopedic surgery. Consideration of fresh fractures, plaster technic, and orthopedic apparatus is excluded. From the standpoint of the medical student and general practitioner, as well as of students in the allied fields of physical medicine, x-ray, and medical-social work, this book continues to be a highly readable, authoritative presentation of the causes and effects of bone and joint disease; and the original intent of the author to produce a useful volume of handbook proportions has been maintained.

The author has improved upon the original edition; and discussions of arachnodactyly, gargoylism, Morquio's disease, fibrous dysplasia, brucellosis, gout, the foot of the normal child, and radiohumeral subluxation in children are now included.

The book is strongly recommended; and its moderate price, as textbooks go nowadays, should facilitate replacement of an earlier edition.—H.I.O.

**Pheochromocytoma and the General Practitioner.** Monograph by Joseph L. DeCourcy, M. D., and Cornelius B. DeCourcy, M. D., DeCourcy Clinic, Cincinnati, Ohio. Barclay Newman, 1952.

The title of this monograph acts as a misnomer for its actual contents. Although entitled the "Pheochromocytoma and the General Practitioner," its scope is such as to be of interest to the medical historian, the internist, and the surgeon. The authority of the statements is based on personal experience as well as on that of the 342 references cited from the literature. On this basis, and at the expense of repetition and verbosity, it serves to direct the physician's attention to this condition as an increasing entity in the realm of the curable forms of hypertension. In so doing, the authors have entered into the greatest of detail, beginning with the history of this condition and ending with a rather complete description of their own surgical technics in correcting it.—A.P.C.

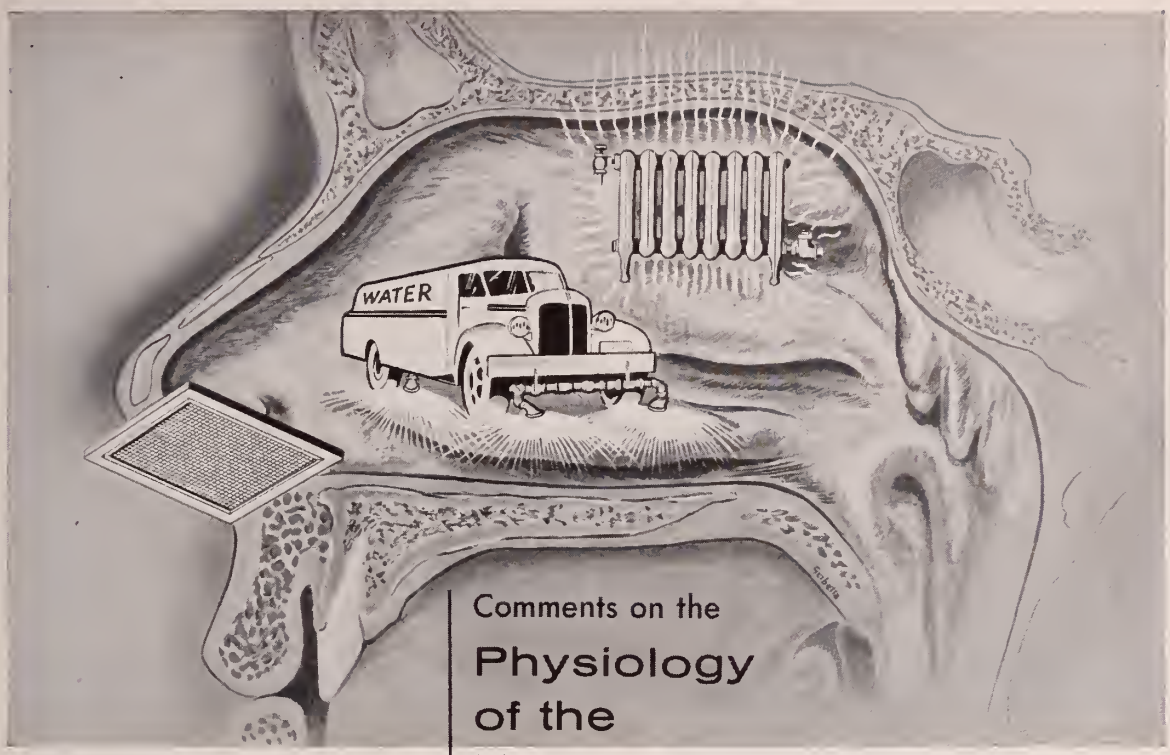
**Mayo Clinic Diet Manual.** The Committee on Dietetics of the Mayo Clinic. Second Edition. Philadelphia and London, W. B. Saunders Company, 1954.

This second edition reflects changes in the Mayo Clinic dietary practice. Food values have been recalculated to conform to U. S. Department of Agriculture Handbook No. 8.

The diets in the manual have again been classified according to the nature of the metabolic disturbance. A general description of each diet and an analysis of its nutrient content are given. Foods to include and exclude are listed, and a very helpful menu pattern is presented for each diet. Test diets are included.

A section of the manual is devoted to the calculation and preparation of infant formulas and dietary programs for children. The appendix includes height-weight tables and many tables on food composition. These tables would be more useful to the clinician if they were on the basis of serving portions, rather than 100 gram portions.

This manual will be useful to the physician in private practice. The diet plans can be easily adapted to patient use. The manual is not adapted to the use of the small hospital with limited dietary staff. To serve such a variety of diets would require a relatively large staff of well-trained dietary personnel.—R. S. D.

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**A Manual of Clinical Allergy.** By John M. Sheldon, M. D., professor of internal medicine, University of Michigan Medical School, assistant to the chairman of the department of postgraduate medicine, physician in charge of University of Michigan allergy clinics, director of the Montgomery Allergy Research Laboratory; Robert G. Lovell, M. D., instructor in internal medicine, University of Michigan Medical School; and Kenneth P. Mathews, M. D., assistant professor of internal medicine, University of Michigan Medical School. Philadelphia and London, W. B. Saunders Company, 1953.

This readable manual should be a practical addition to the library of any physician interested in allergy. Special consideration is given the problems encountered daily in an allergy practice. Carefully prepared lists of commercial products containing common antigens are reproduced.

The practical aspects of treatment are discussed in so much detail that the reader feels he has had an intimate and detailed visit in the authors' clinics and laboratories. The preparation of treatment and testing materials is carefully discussed. The production of bacterial vaccine is also considered.

This work has the virtues of being concise, readable, and usable. It is recommended for the medical library, student, and practitioner.—J.R.T.

**Synopsis of Pathology.** By W. A. D. Anderson, M. A., M. D., F.A.C.P., Professor of Pathology, Marquette University School of Medicine; Pathologist, St. Joseph's Hospital, Milwaukee, Wisconsin. Third Edition. St. Louis, The C. V. Mosby Company, 1952. Price $8.00.

The reappearance of this synopsis in which the fundamentals of pathology are conveniently condensed requires recognition of the virtues which have established its recurrent reproduction. The wordy elegance and individual circumlocutions which both lengthen perusal and enhance the literary appeal of most texts on the subject are minimized but not excluded. Preference is afforded to concise representation of essential pathology by ample, excellent photographic material and illustrative plates, of which over 300 examples are crowded into the compact volume. The author has not only supplied the requisite information concerning lesions but has included a bibliography adequately modern and of sufficient authoritative value. Cognizance of many significant pathological observations which have occurred since the previous edition represents the care manifested in all departments to insure a current utility. Some inclusions, such as the reference to the carotid tumor as a chemodectoma, border on the esoteric, although these aberrations from conventional attitudes provide an incidental salutary entertainment which softens the impact of the mass of condensed pathology.—J.W.H.

**The Medical Clinics of North America.** Philadelphia and London, W. B. Saunders Company, 1952.

The September 1952 issue of this series of monographs is a symposium on Specific Methods of Treatment. The 22 essays cover such diverse areas as burns, asthma, tuberculosis, thrombo-embolism, peptic ulcer, leukorrhea, physical medicine, induction of labor, and the treatment of reversible uremia.—R. F. S.

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**The Toxemias of Pregnancy.** By William J. Dieckmann, S. B., M. D., Mary Campau Ryerson Professor and Chairman of the Department of Obstetrics and Gynecology of the University of Chicago; Chief of Service of the Chicago Lying-in Hospital and Dispensary; Attending Gynecologist, Albert Merrit Billings Memorial Hospital of the University of Chicago; Associate Editor of the American Journal of Obstetrics and Gynecology. Second Edition. St. Louis, C. V. Mosby Company, 1952. Price $14.50.

This text, in its second edition, is an excellent treatise on the toxemias of pregnancy. It is all inclusive, from every standpoint, in the consideration of the toxemias of pregnancy. It can be highly recommended to every obstetrician and should be in his reference library.—R.E.C.

**Atlas of Surgical Exposures of the Extremities.** By Sam W. Banks, M. D., Associate Professor of Orthopedic Surgery, Northwestern University Medical School, Attending Orthopedic Surgeon, Chicago Memorial Hospital and Woodlawn Hospital; and Harold Laufman, M. D., Ph. D., Associate Professor of Surgery and Director of Experimental Surgery, Northwestern Medical School, Associate Attending Surgeon, Michael Reese Hospital. Philadelphia and London, W. B. Saunders Company. 1953.

This is a pictorial atlas. The illustrations have been done by Miss Jean McConnell, Northwestern University Medical School, for the most part; and they are excellent. The illustrations are uncolored, although the detail drawing is exquisite; and one is not conscious of the lack of coloring.

The book is arranged excellently into sections dealing with the areas from shoulder to ankle, and incisions used for exposure of these areas are presented.

The description of the operation in the various stages of the exposure is given on the left-hand page, and the drawings for each stage of the exposure are presented on the right-hand page. The detail is adequate. The description is concise and quite clear. The indications for each exposure are given. However, one must be aware that the choice of exposure is in part dependent on the ability of the surgeon and therefore individualistic. It is not necessarily the only exposure of choice for the indicated operation. Any surgeon might disagree with some exposure presented for, shall we say, such an operation as an open reduction of congenital dislocation of the hip.

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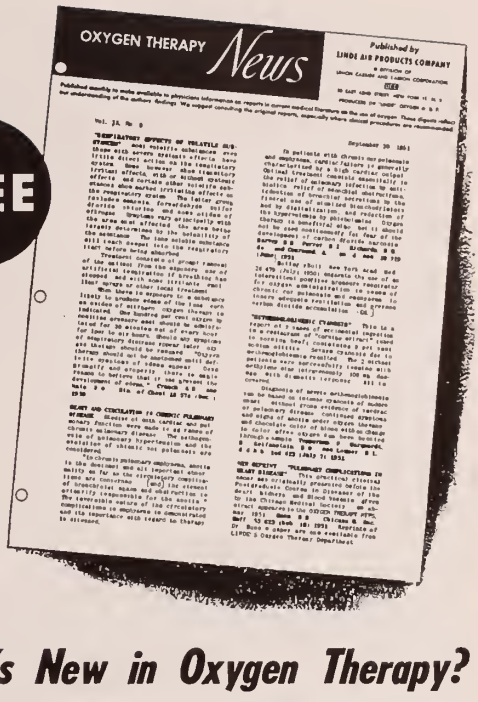


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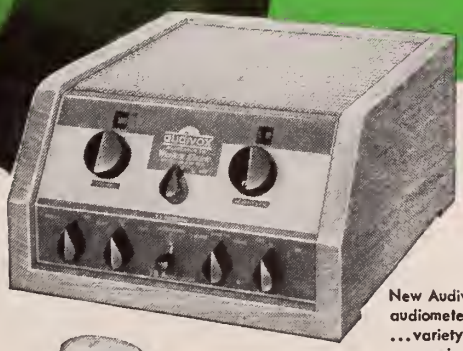

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| Mather Pharmacy | 4 |
| Mead Johnson and Company | 45 |
| Medical Protective Company | 26 |
| Milwaukee Sanitarium | 46 |
| New York Polyclinic | 36 |
| Orthopedic Appliance Company | 36 |
| Parke, Davis and Company | 2, 3 |
| Pfizer Laboratories, Division of Chas. Pfizer & Company, Inc. | 17 |
| Physicians Casualty Association | 30 |
| Pogue, Mary E., School | 30 |
| Rennebohm's | 4 |
| Roemer Drug Company | 38 |
| Rogers Memorial Sanitarium | 46 |
| S. and L. Signal Company, Inc. | 29 |
| Sacred Heart Sanitarium | 28 |
| St. Croixdale Sanitarium | 5 |
| Schieffelin and Company | 38 |
| Searle, G. D. and Company | 19 |
| Shorewood Hospital Sanitarium | 21 |
| Upjohn | 7 |
| Wine Advisory Board | 16 |
| Winthrop-Stearns, Inc. | 33 |
| Wisconsin Neurological Foundation | 25 |
| Wyeth | 14 |

# THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

A. J. McCAREY, Green Bay
E. L. BERNHART, Milwaukee
L. O. SIMENSTAD, Osceola, Speaker

J. W. FONS, Milwaukee, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

**Councilors**

R. G. ARVESON, Frederic, Chairman

S. E. GAVIN, Fond du Lac, Chairman Emeritus

TERM EXPIRES 1954

First District:
W. D. James_____Oconomowoc
Second District:
L. H. Lokvam_____Kenosha

TERM EXPIRES 1955

Third District:
N. A. Hill_____Madison

TERM EXPIRES 1954

H. E. Kasten_____Beloit

TERM EXPIRES 1955

Fourth District:
E. M. Dessloch___Prairie du Chien

TERM EXPIRES 1955

Fifth District:
A. H. Heidner_____West Bend
Sixth District:
A. J. McCarey_____Green Bay

TERM EXPIRES 1956

Seventh District:
J. C. Fox_____La Crosse
Eighth District:
J. M. Bell_____Marinette
Ninth District:
R. E. Garrison__Wisconsin Rapids
Tenth District:
R. G. Arveson_____Frederic
(Chairman)

TERM EXPIRES 1954

Eleventh District:
V. E. Ekblad_____Superior
Twelfth District:
R. E. Galasinski_____Milwaukee
E. L. Bernhart_____Milwaukee
N. J. Wegmann_____Milwaukee

TERM EXPIRES 1955

W. T. Casper_____Milwaukee

TERM EXPIRES 1956

Thirteenth District:
C. E. Zellmer_____Antigo

TERM EXPIRES 1954

H. Kent Tenney_____Madison
(Past-President)

**Delegates to American Medical Association**
(Terms end on December 31 of year indicated)

Stephen E. Gavin, Fond du Lac, 1954
D. H. Witte, Milwaukee, 1954
William D. Stovall, Madison, 1955

**Alternates**

L. O. Simenstad, Osceola, 1954
Joseph C. Griffith, Milwaukee, 1954
G. E. Forkin, Menasha, 1955

The Wisconsin Medical Journal, Official Publication
Advertising Representative: State Journal Advertising Bureau, 535 North Dearborn St., Chicago, Illinois

## List of Officers and Scheduled Meetings of County Medical Societies

| COUNTY | PRESIDENT | SECRETARY | MEETING DATE |
|---|---|---|---|
| Ashland-Bayfield-Iron | W. J. Tucker<br>Ashland | J. M. Jauquet<br>901 9th Ave., W.<br>Ashland | |
| Barron-Washburn-Sawyer-Burnett | W. F. Vaudreuil<br>Rice Lake | D. F. Hammond<br>Chetek | Second Tuesday<br>7:30 p.m. |
| Brown-Kewaunee-Door | G. B. Merline<br>De Pere | G. M. Shinners<br>409 E. Walnut<br>Green Bay | Second Thursday* |
| Calumet | F. P. Larme<br>New Holstein | J. M. Guthrie<br>Brillion | |
| Chippewa | C. A. Kemper<br>119½ Bridge<br>Chippewa Falls | Paul Murphy<br>Bloomer | Second Tuesday |
| Clark | K. F. Manz<br>Neillsville | J. W. Koch<br>Colby | |
| Columbia-Marquette-Adams | J. P. Harkins<br>Portage | F. W. Gissal<br>132 Washington Ave.<br>Wisconsin Dells | Every Third Month<br>7:00 p.m. |
| Crawford | | H. L. Shapiro<br>Prairie du Chien | |
| Dane | S. L. Chase<br>905 University Ave.<br>Madison | G. E. Oosterhous<br>304 W. Washington<br>Madison | Second Tuesday |
| Dodge | Leonard Schrank<br>Waupun | R. F. Boock<br>119½ Front<br>Beaver Dam | Last Thursday* |
| Douglas | C. J. Picard<br>2029 E. Fifth<br>Superior | R. P. Fruehauf<br>1514 Ogden<br>Superior | First Wednesday**<br>Badger Room of the<br>Hotel Superior |
| Eau Claire-Dunn-Pepin | K. L. German<br>219 S Barstow<br>Eau Claire | G. E. Wahl<br>616 E. Grand<br>Eau Claire | Last Monday |
| Fond du Lac | N. O. Becker<br>104 S. Main<br>Fond du Lac | H. J. McLane<br>80 Sheboygan St.<br>Fond du Lac | Fourth Thursday* |
| Forest | O. S. Tenley<br>Wabeno | D. V. Moffet<br>Crandon | |
| Grant | E. M. Randall<br>Boscobel | H. W. Carey<br>Lancaster | Last Thursday.<br>March, June,<br>Sept. and Nov. |
| Green | N. E. Bear<br>Monroe | D. E. Mings<br>Monroe Clinic<br>Monroe | |
| Green Lake-Waushara | Russell Pelton<br>Markesan | L. S. Shemanski<br>Wautoma | Last Thursday,<br>every other month<br>starting in Jan. |
| Iowa | C. L. White<br>Mineral Point | H. M. Walker<br>Dodgeville | First Thursday<br>following<br>first Monday |
| Jefferson | E. J. Netzow<br>Lake Mills | H. N. Hunsader<br>111 S. Main<br>Fort Atkinson | Third Thursday* |

* Except June, July, and August.

** Except July and August.

## List of Officers and Scheduled Meetings of County Medical Societies—Continued

| COUNTY | PRESIDENT | SECRETARY | MEETING DATE |
|---|---|---|---|
| Juneau | J. S. Hess<br>Mauston | John E. Thompson<br>Mauston | Second Tuesday<br>Hess Clinic in<br>Mauston |
| Kenosha | Richard M. Block<br>520 58th<br>Kenosha | Helen A. Binnie<br>7609 25th<br>Kenosha | First Thursday*<br>Elks Club<br>Kenosha |
| La Crosse | C. F. Midelfort<br>1836 South Ave.<br>La Crosse | Arnold A. Cook<br>1707 Main<br>La Crosse | Third Monday |
| Lafayette | N. A. McGreane<br>128 E. Ann St.<br>Darlington | R. E. Oertley<br>Darlington | Last Tuesday |
| Langlade | M. J. Donohue<br>Antigo | F. H. Garbisch<br>Antigo | Second Wednesday |
| Lincoln | Walter Lewinnek<br>700 E. Third<br>Merrill | J. D. Millenbah<br>Merrill | |
| Manitowoc | Nelson Bonner<br>709 Washington<br>Manitowoc | W. S. Marshall<br>1522 Washington<br>Two Rivers | Last Thursday |
| Marathon | H. W. Christensen<br>501½ Third<br>Wausau | A. W. Hoessel<br>115 McIndoe<br>Wausau | |
| Marinette–Florence | Kenneth Moss<br>1554 Main<br>Marinette | R. J. Rogers<br>Oconto | Third Wednesday<br>St. Joseph's Hospital |
| Milwaukee | J. G. Garland<br>324 E. Wisconsin<br>Milwaukee | Donald M. Willson<br>324 E. Wisconsin<br>Mr. J. O. Kelley, Ex. Sec.<br>208 E. Wisconsin | Second Thursday |
| Monroe | C. E. Kozarek<br>Tomah | J. S. Mubarak<br>Tomah | Third Monday |
| Oconto | F. E. Zantow<br>Oconto | G. R. Sandgren<br>Suring | |
| Oneida–Vilas | G. R. Thuerer<br>1020 Kabel<br>Rhinelander | Marvin Wright<br>1020 Kabel<br>Rhinelander | Monthly |
| Outagamie | W. A. Adrians<br>103 W. College<br>Appleton | J. E. Gmeiner<br>103 W. College<br>Appleton | Third Thursday*<br>Elks Club<br>6:30 p.m. |
| Pierce–St. Croix | F. B. Klaas<br>East Ellsworth | P. H. Gutzler<br>River Falls | Third Tuesday |
| Polk | H. A. Dasler<br>Cornwall Clinic<br>Amery | L. J. Weller<br>Osceola | Third Thursday<br>7 p.m. |
| Portage | V. A. Benn<br>Rosholt | H. A. Anderson<br>Stevens Point | * |
| Price–Taylor | E. B. Elvis<br>Medford | J. J. Leahy<br>Park Falls | Last Saturday,<br>Feb., May, Aug.,<br>and Nov. |
| Racine | G. L. Rothenmaier<br>3115 Washington Ave.<br>Racine | Eugene Pitts<br>420 Seventh<br>Racine | Third Thursday |
| Richland | W. C. Edwards<br>Richland Center | L. M. Pippin<br>Richland Center | First Tuesday<br>Richland Hospital |
| Rock | Milton Davis<br>Milton | H. M. Snodgrass<br>508 W. Milwaukee<br>Janesville | Fourth Tuesday |
| Rusk | L. M. Lundmark<br>Ladysmith | M. L. Whalen<br>Bruce | First Tuesday |
| Sauk | O. V. Pawlisch<br>Reedsburg | J. J. Rouse<br>Reedsburg | Second Tuesday* |
| Shawano | R. C. Cantwell<br>Shawano | A. J. Sebesta<br>Shawano | Third Tuesday |
| Sheboygan | J. F. Kovacic<br>925A N. Eighth<br>Sheboygan | Keith M. Keane<br>1011 N. Eighth<br>Sheboygan | First Thursday |
| Trempealeau–Jackson–Buffalo | O. M. Schneider<br>Blair | E. P. Rohde<br>Galesville | Fourth Tuesday |
| Vernon | L. F. Gulbrandsen<br>Viroqua | DeVerne W. Vig<br>Viroqua | Last Wednesday |
| Walworth | R. A. Moses<br>Delavan | Glen Smiley<br>Delavan | Second Thursday* |
| Washington–Ozaukee | T. D. Elbe<br>Thiensville | F. I. Bush<br>West Bend | Fourth Thursday |
| Waukesha | Peter Theobald<br>Oconomowoc | F. A. Thompson<br>725 American Ave.<br>Waukesha | |
| Waupaca | J. W. Monsted<br>New London | J. J. Mulvaney<br>32 S. Main<br>Clintonville | |
| Winnebago | B. S. Greenwood<br>19 Jefferson Ave.<br>Oshkosh | G. B. Hildebrand<br>216½ Main<br>Menasha | First Thursday |
| Wood | H. G. Pomainville<br>Wisconsin Rapids | N. J. Helland<br>Marshfield | Four times a year |

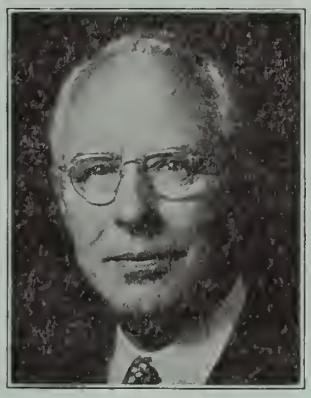
* Except June, July, and August.

SUPPLEMENT TO THE WISCONSIN MEDICAL JOURNAL
October 1954

# THE MEDICAL FORUM

# SPECIAL REPORT ON MEDICAL SOCIETY MEETING

DR. BERNHART



DR. McCAREY

## BERNHART NAMED PRESIDENT-ELECT

### Drs. James and Lockvam Named to Council

Milwaukee, Oct. 6.—Dr. Ervin L. Bernhart, Milwaukee, general practitioner, was named president-elect of the State Medical Society by the House of Delegates during the final business session of its annual meeting in Milwaukee. The 55-year-old physician will take office as president in May, 1955.

**Active in medical organizational work, Dr. Bernhart has been a councilor and a member of the House of Delegates of the state society. He is a past-president of both the Medical Society of Milwaukee County and the Wisconsin Academy of General Practice.**

**Other Officers Named**

Other officers elected at the meeting were Dr. L. O. Simenstad, Osceola, speaker of the House of Delegates, and Dr. J. W. Fons, Milwaukee, vice-speaker of the House. Drs. S. E. Gavin, Fond du Lac, and D. H. Witte, Milwaukee, were re-elected as delegates and Drs. L. O. Simenstad, Osceola, and J. C. Griffith, Milwaukee, as alternate delegates to the American Medical Association.

**Two physicians were elected to**

*(Continued on page 3)*

## McCarey Announces Committee Appointees

Milwaukee, Oct. 4.—Dr. A. J. McCarey, Green Bay, incoming president of the State Medical Society, announced the appointment of 16 physicians to 8 committees of the society.

The appointments were made at the opening session of the House of Delegates at the Schroeder Hotel in Milwaukee.

**To the Committee on Cancer which develops cancer education programs for physicians and the public in cooperation with the Wisconsin Division of the American Cancer Society, Dr. McCarey appointed Drs. R. P. Welbourne, Watertown; A. C. Taylor, Appleton; P. B. Blanchard, Cedarburg; and C. W. Giesen, Superior. Dr. Welbourne will serve as chairman.**

**List Others**

Dr. J. W. Nellen, Green Bay, was appointed to the Committee on Coordination of Medical Services which studies admission procedures at Wisconsin General Hospital. Dr. J. F. Wilkinson, Oconomowoc, will serve as chairman.

Dr. R. E. Fitzgerald, Milwaukee, was renamed chairman of the society's Grievance Committee which handles any complaints from physicians or the public concerning

*(Continued on page 4)*

## Doctor McCarey Takes Office As Society President

**Milwaukee, Oct. 6.—Dr. A. J. McCarey, Green Bay, took office as president of the State Medical Society during the annual meeting in Milwaukee.**

He will serve as president until the next annual meeting in May, 1955. He is a general practitioner and surgeon who has practiced in Green Bay since 1919. Dr. McCarey has served as Councilor from the 6th District and as a member of the House of Delegates from the Brown–Kewaunee–Door Medical Society.

"The development of medicine rests primarily on man's sympathy for man. The desire to be relieved of pain and disability represents a reaction based on the powerful instinct of self-preservation. But the desire to relieve pain and disability in others represents a reaction based on love," he said.

**Need "Love and Mercy"**

"The patient men in the monasteries of Western Europe taught that the care of the sick is a task of love and mercy," Dr. McCarey declared. "These spiritual and humanitarian concepts were woven into the fabric out of which was made the banner of medicine that has been held aloft by generation after generation of Wisconsin doctors."

**"Practicing in this modern, scientific, materialistic world, could it be that we are placing insufficient emphasis on this philosophy of our profession?" Dr. McCarey queried.**

"In these troubled times we must realize more than ever that the welfare of medicine depends, as it always has, on our integrity and our moral responsibility to our patients just as much as on our training and our ability," Dr. McCarey warned.

*(Continued on page 4)*

## *TENNEY PROPOSES INTERPROFESSIONAL INSTITUTES FOR LONG-RANGE PLANNING*

Milwaukee, Oct. 6.—Semiannual interprofessional institutes were authorized by the House of Delegates upon the recommendation of Dr. H. Kent Tenney, Madison, retiring president of the State Medical Society.

Dr. Tenney, in an address to the delegates, proposed that regular interprofessional institutes should be organized at which "top ranking people in fields related to medicine (nursing, pharmacy, dentistry, and hospital) and representatives of various state departments could discuss their problems and work out mutually acceptable programs."

He said that "the increasing complexity of medical practice makes it quite apparent that long-range planning is needed" to answer such questions as:

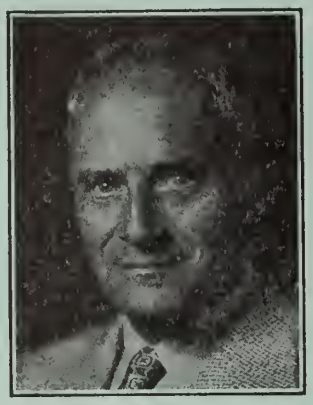
1. **If benefits for dental services are included in our insurance plans, what should be the effect on the dentists' hospital staff privileges?**
2. **Does the trend toward group and clinic practice make the establishment of clinic pharmacies more or less important?**
3. **Is the increase in small hospitals, built with federal funds, outstripping our ability to supply them with necessary ancillary services? In other words, are we sacrificing quality to quantity?**
4. **Are hospital costs rising at such a suicidal rate that some drastically new approach to the problem is necessary?**

The reference committee recommended that Dr. Tenney's proposal be "implemented at the earliest possible time" as a means of handling "matters of common concern before they reach the problem stage."

Dr. Tenney had high praise for the government's role in many areas of preventive medicine, especially its part in joint government-private physician efforts to reduce infant and maternal mortality.

He urged physicians to assume leadership in directing the government's active participation in many other areas of preventive medicine.

Expressing doubt that the federal government can be of "much help" in the insurance field, Dr. Tenney characterized the administration's reinsurance proposals as a "vast federal subsidy which would surely soon take on the political attributes which now characterize farm subsidies."



DR. TENNEY

**Nevertheless, Dr. Tenney called upon physicians to recognize a "deep-seated political and sociologic trend toward participation of government in the health of the people as a fact of life." He added, "the quicker we start making specific proposals as to specific things government can do the quicker we will gain and merit the confidence of legislators."**

## Ask AMA to Give States Time to Study Important Matters

Milwaukee, Oct. 6.—Wisconsin AMA delegates will seek to convince the AMA house of delegates that it should give more time for the membership of the state societies to consider matters brought before it prior to taking official action.

It is felt this would lead to better understanding of AMA policy and establishment of policy that has greater backing of the membership prior to its enactment.

Wisconsin delegates at the next AMA session are to request that "action on any resolutions not submitted to the AMA thirty days in advance of a session be held over to the next session, except where an appropriate committee rules that the matter requires immediate action."

## Society to Meet with Legion on Veterans' Problems

Milwaukee, Oct. 6.—The House of Delegates of the State Medical Society, at its final business session, voted to appoint a liaison committee of three to five members to meet with the American Legion in Wisconsin to work out differences concerning the medical care of veterans.

The proposal was made by Dr. E. Cary, Reedsville. He is a past state vice-commander of the Legion.

**Dr. Cary asked for the committee because "there is apparently a great deal of misunderstanding between the American Medical Association and the American Legion, and I see no reason why two great organizations should not be able to sit around a table and settle their differences."**

Referring to the American Legion's dispute with the American Medical Association concerning the care of veterans with non-service-connected disabilities, Dr. Cary said, "I just want to straighten this thing out."

The American Medical Association contends that to treat such veterans at government expense is "creating a special class of citizens." The AMA prefers that they receive medical attention from their family physicians and in local hospitals rather than being cared for in Veterans Administration facilities. In the event such veterans are unable to pay for their care, the AMA believes their cases should be handled through local welfare agencies.

## Continue Cancer Clinics for M.D.'s and Dentists

Milwaukee, Oct. 6.—Physicians must continue to be alert to the opportunities for early diagnosis of cancer, the House of Delegates declared in approving the report of the Committee on Cancer.

Under the chairmanship of Dr. R. P. Welbourne, Watertown, the committee reported that the public should be encouraged to place a higher value on periodic checkups.

The committee was commended for developing a highly successful series of special teaching programs for physicians and dentists, and asked that these be continued.

# FEAR BLUE CROSS-SHIELD PLAN FOR FEDERAL EMPLOYEES

Milwaukee, Oct. 6.—A proposal to enroll some 3,000,000 federal employees in Blue Cross–Blue Shield has been tagged as "an insurance monstrosity" and more "snowballing down the road to socialism."

News of the proposal was revealed to the Commission on Prepaid Plans and the Council during the Annual Meeting of the State Medical Society, and the House of Delegates heard a first-hand report of the matter from C. H. Crownhart, secretary of the Society.

**Fearing that the plan might be an opening wedge for government control of medical care and the eventual destruction of local Blue Shield plans, the House of Delegates expressed confidence in the judgment of the Council and Commission on Prepaid Plans on the matter.**

### Background Given

Here is the background of the situation:

Blue Shield of Wisconsin (Wisconsin Physicians Service), along with nearly 80 other Blue Shield plans, is a member of the national Blue Shield Commission. Local Blue Cross plans have a similar organization at the national level.

About 1948 the "Blue" plans were told that large manufacturing concerns with employees in different states wanted to buy Blue Shield and Blue Cross from one source and on a uniform basis for all their employees. These were termed "national accounts."

To accomplish the enrollment of such accounts, the national Blue Shield and Blue Cross plans set up two regular insurance companies. One, known as Health Service, Inc., is wholly owned by Blue Cross. The other, known as Medical Indemnity of America, is wholly owned by Blue Shield.

### New Income Levels

However, these two plans are in reality only one, since they are jointly administered and each reinsures 50% of the risks acquired by the other.

Since Health Service and MIA were established they have defined a "national account" as any account where the subscribers reside in the area of more than one plan, and there is a mechanism for a single source of payment of the premium. This includes unions, national associations and the like.

During the last session of Congress, a law was passed permitting payroll deduction and government participation in the cost of life insurance for federal employees.

**It is reported that national Blue Shield is currently negotiating a plan with the Federal Civil Service Commission whereby a law can be passed in the next session specifying that federal employees can have a service (Blue Shield) type surgical-medical plan on the same basis as the life insurance.**

This might result in the enrollment of nearly 3,000,000 federal employees, about 25,000 in Wisconsin, with a total annual premium of about $100,000,000.

**It is proposed that the plan provide "full payment" for employees without dependents whose annual income is $4,000 or less and for those with dependents whose income is less than $5,000. Blue Shield of Wisconsin has income levels of $3,000 and $4,800 under the "A" schedule.**

### Voices Seven Fears

About 85% of all federal employees would be eligible for "full payment" under the proposal.

Crownhart labelled the plan an "insurance monstrosity," saying it did not seem likely that free choice of physician could be preserved under the system.

He said he was concerned that:

1. **the negotiations might include "limited licensees" along with physicians.**
2. **a uniform fee schedule would be a "natural consequence" of a uniform level for full payment.**
3. **the full payment levels would tend to be increased.**
4. **the program, once started, would be extended to other fields of federal interest, such as public welfare cases, the aged, and veterans.**
5. **the government might later decide that some kinds of medical service—pathology, radiology, etc.—might be obtained cheaper through government employees and laboratories than through private practitioners under the insurance plan.**
6. **the government might set limitations on the use of medications, such as have been experienced with the VA hometown care program.**
7. **panels of physicians might be set up for providing certain specific or specialized procedures.**

Dr. E. M. Dessloch, Prairie du Chien, chairman of the Commission on Prepaid Plans in Wisconsin, expressed doubt that the national plan could be stopped. "We're still snowballing down the road to socialism, but I guess the majority still rules." He felt that most other Blue Shield plans seemed to favor it.

The House of Delegates later voted to return the matter to the Council and Commission for follow-up. The Council then determined that Blue Shield of Wisconsin should oppose the plan as outlined to date and press for enrollment of the federal employees in Blue Shield on a nationwide basis, but with each state's Blue Shield plan covering the federal employees in its own area with its own plan.

## BERNHART NAMED . . .

*(Continued from page 1)*

**three-year terms on the Council of the society. They were Drs. W. D. James, Oconomowoc (1st District), and L. H. Lokvam, Kenosha (2nd District). Drs. H. E. Kasten, Beloit; V. E. Ekblad, Superior; R. E. Galasinski, Milwaukee; E. L. Bernhart, Milwaukee; and N. J. Wegmann, Milwaukee, were re-elected as Councilors.**

Other Councilors whose terms continue are Drs. N. A. Hill, Madison; E. M. Dessloch, Prairie du Chien; A. H. Heidner, West Bend; A. J. McCarey, Green Bay; J. C. Fox, La Crosse; J. M. Bell, Marinette; R. E. Garrison, Wisconsin Rapids; R. G. Arveson, Frederic; W. T. Casper, Milwaukee; and C. E. Zellmer, Antigo.

As president-elect, Dr. Bernhart will immediately become a member of the society's Interim Committee which directs business affairs of the group between council meetings.

*Milwaukee Journal Photo*

**AMA exhibit on Mechanical Quackery was a headliner at the annual meeting in Milwaukee. Here Richard Stalvey, Chicago, assistant director of the AMA's Bureau of Investigation, demonstrates a "spectrochrome" device featuring colored lights for different diseases. The exhibit is available from the AMA for showing at fairs and meetings.**

## WPS Reports Enrollment of Nearly 295,000

### Pays $3,000,000 in Benefits

Milwaukee, Oct. 6.—Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society, reports an enrollment of 294,439 on June 30.

In a report adopted by the House of Delegates, the Commission on Prepaid Plans revealed that benefit payments during the year ending June 30, 1954, hit an all time high at over $3,000,000. About 6,000 cases are handled each month.

Over half of the benefits paid were to women; 56% were paid under the "B" schedule of benefits, and 78% were paid to participating physicians.

New developments during the year included the offering of Major Illness Expense Insurance, maternity benefits on non-group contracts, and a special non-group enrollment in northwestern Wisconsin.

In the first six months of 1954, Physicians Indemnity Plan, set up to handle state groups under national Blue Shield accounts, paid a total of 1,251 cases amounting to nearly $65,000. The Wisconsin Plan has 11 large insurance companies participating in its program.

## Society Membership Up to 3,187

Milwaukee, Oct. 6.—State Medical Society membership among Wisconsin physicians is on its way to a new high, according to a report presented to the House of Delegates.

Membership now totals 3,187. The American Medical Association reports about 3,700 physicians in Wisconsin in 1953. A breakdown of the Society's membership on September 15, 1954 shows the following classifications of members:

| | |
|---|---|
| Regular | 2,742 |
| Resident | 117 |
| Associate | 44 |
| Affiliate | 54 |
| Life | 60 |
| Military | 115 |
| Honorary | 8 |
| Educational | 0 |
| Age exempt by AMA | 40 |
| Service fellows | 8 |
| Delinquent | 85 |

The House of Delegates was informed that Wisconsin would receive another delegate to the American Medical Association by virtue of going over 3,000 membership. AMA delegates are appointed on the basis of one delegate for every 1,000 members or fraction thereof.

## McCAREY ANNOUNCES . . .

*(Continued from page 1)*

the practices of physicians. Dr. McCarey also appointed Drs. C. E. Zellmer, Antigo, and C. D. Neidhold, Appleton, as members of the committee.

**Drs. A. H. Barr, Port Washington, and S. R. Beatty, Neenah, were named to the Hospital Relations Committee which deals with mutual problems between medical staffs and hospital administrators. Dr. Barr will serve as chairman for 1954–55.**

Dr. T. L. Squier, Milwaukee, was appointed chairman of the Committee on Medical Education and Hospitals which works to improve standards of medical education and hospital care in Wisconsin. Dr. I. E. Schiek, Jr., Rhinelander, was appointed to serve as a member of the committee.

**Dr. D. E. Dorchester, Sturgeon Bay, was renamed chairman of the Council on Medical Services which handles matters of health education, industrial health and rural health. Drs. R. L. MacCornack, Whitehall, and H. J. Kief, Fond du Lac, were appointed to membership on the committee.**

Dr. J. M. Sullivan, Milwaukee, was reappointed chairman of the Public Policy Committee which develops the society's legislative program. Dr. J. A. Enright, Milwaukee, was appointed a member of the committee.

**Dr. K. E. Lemmer, Madison, was named to the Council on Scientific Work which develops all scientific programs, including the annual meeting, of the Society.**

## DOCTOR McCAREY . . .

*(Continued from page 1)*

**"We must continue to direct our Society and ourselves along the path of truth, righteousness, and devoted service to our fellow men," Dr. McCarey concluded.**

Urging continued cooperation from physicians, Dr. McCarey called the Blue Shield health insurance plan of the Society "one of the most outstanding enterprises ever undertaken by us."

He urged doctors to give generously to the American Medical Education Foundation, an AMA fund to aid medical schools. He pointed out that Wisconsin's contribution to date "has not yet measured up to what we all know it can do in this direction."

# "Need Medical History to Meet Attacks on Profession:" McNeil

Milwaukee, Oct. 6.—"During these times when the medical profession is under attack, and when critics are charging that doctors have a this-world complex, we need a study of Wisconsin's medical history more than ever before," Don McNeil, assistant director of the Wisconsin State Historical Society, declared at the first meeting of the State Medical Society's Section on Medical History.

About 50 medical society and auxiliary members attended. A total of 141 members of the medical society are members of the Section.

McNeil stated: **"When great forces are attempting to curb the individual's initiative and when specialization threatens to turn the doctor into a robot interested in a restricted sphere of medicine and human knowledge, an appreciation of medical history facts will help us all profit from the mistakes of the past."**

McNeil reported the progress made on a medical history project since the medical society made a $2,500 grant to the historical society. Thousands of documents have been obtained, including several hundred books, rare museum pieces illustrating medical practices of by-gone days, and many artifacts of various types.

"We want more of these documents and this new section on medical history is a perfect vehicle for perpetuating the heritage of the profession," McNeil said.

"We hope to use these documents for research and writing of local and state history from which the public can gain a better appreciation of how the profession has grown and what it is doing," he added.

**Dr. W. D. Stovall, Madison, was named chairman of the Section for the coming year. Dr. W. S Middleton, Madison, is vice-chairman, and C. H. Crownhart, Madison, is secretary-treasurer.**

The Section voted to add a member of the Woman's Auxiliary as vice-chairman. Mrs. Victor Falk, Edgerton, president of the Auxiliary; Mrs. A. J. McCarey, Green Bay; and Mrs. E. M. Dessloch, Prairie du Chien, explained local history-keeping efforts. Dues for the Section were set at $10 per year.

**DR. STOVALL**
**Chairman, Section on Medical History**

# Neupert Urges More Attention to Preventive Medicine

Milwaukee, Oct. 6.—An appeal for physician assistance in preventive medical activities was voiced by Dr. Carl N. Neupert, Madison, state health officer, at a meeting of the House of Delegates.

"There are economic as well as health aspects to preventive medicine," Dr. Neupert pointed out. "For example, from 1911 to 1925 the Metropolitan Life Insurance Company spent 20 million dollars on health education, promotion of early diagnosis and nursing services for its policyholders. The result: a 30 per cent reduction in death rate, twice that of the general population, and a saving of 43 million dollars to the company."

**"Prevention is a good investment," Dr. Neupert said. "Expenditure of tax funds for public assistance, aid to dependent children, and old age assistance are on the increase. To an appreciable extent health failure is a contributing factor to the need for that assistance. That portion will continue to grow except as preventive measures are applied."**

"Certain portions of prevention of health neglect can be done best by an official government agency," Dr. Neupert declared. "We in the State Board of Health are proud of our joint efforts and accomplishments with you practicing physicians, and we look forward to greater ones as we go on."

# Large Draft Calls Planned Before July 1

Milwaukee, Oct. 6.—Older physicians are expected to escape the "draft" if the Special Registration Law expires as expected on July 1, 1955.

This word was included in the report of the Committee on Military Medical Service, of which Dr. F. L. Weston, Madison, is chairman.

A large number of men up to age 32 in Priorities I, II and III will be called before that date, however.

The House commended the Councilors of the State Medical Society and others who advised the Wisconsin Advisory Committee to Selective Service. Similarly praised were officials of the State Selective Service System for their fine cooperation.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# REPORT ON COOPERATION WITH STATE DEPARTMENTS

Milwaukee, Oct. 6.—The Commission on State Departments, composed of nearly 100 physician members working in nine separate divisions, has "provided many avenues through which better cooperation between departments of state government in Wisconsin and the State Medical Society has been attained."

**The House of Delegates commended the Commission and its nine divisions for its comprehensive report on activities of the past year. The chairman of the Commission is Dr. T. W. Tormey, Jr., Madison.**

### Crippled Children

Dr. H. A. Sincock, Superior, chairman of the Division on Crippled Children, reported continued close cooperation with the Bureau for Handicapped Children which has been able to reach approximately 14,000 handicapped children under 21 during the past year.

**The division urged that, when patients visit an orthopedic clinic, their family physician should accompany them, or if he is unable to do so, that a close contact be kept with the orthopedist in charge so that proper after care will be followed.**

### Geriatrics

The Division on Geriatrics, last year under the chairmanship of Dr. J. A. Schindler, Monroe, submitted a progress report stating that it is developing a guide to be used by county medical societies in regard to the establishment of nursing homes. It is also studying geriatric factors in automobile accidents and proposals for conferences on medical, social and economic problems of the aged.

### Maternal and Child Welfare

Maternal mortality surveys, fetal-neonatal studies, institutes on premature care and studies of anesthesia practices were among the projects developed during the past year by the Division on Maternal and Child Welfare, Dr. Robert F. Purtell, Milwaukee, chairman.

The maternal mortality survey is reported in greater detail in this issue of the *Medical Forum.* The committee recommended, and the House approved, recommendations that:

**1. Every hospital staff and county medical society hold at least one meeting during 1955 for presentation of the findings and conclusions of the maternal mortality study.**

DR. TORMEY

2. All doctors and hospital staffs should give greater attention to accuracy in completing death certificates and reporting supplemental information obtained from postmortem examination.

3. All hospitals should give special attention to the care of the premature and participate in future institutes on this subject.

**4. Hospital staffs should explore ways of increasing the number of pregnancies carried to term.**

**5. Studies should be initiated at once concerning anesthesia practices related to obstetrics, especially the role of caudal anesthesia.**

### Nervous and Mental Diseases

Under the direction of chairman Dr. E. D. Schwade, Milwaukee, the Division on Nervous and Mental Diseases carried on studies concerning clinical psychologists, commitment laws, and the disturbed child. It was the conclusion of the Division, approved by the Reference Committee and the House of Delegates, that:

1. Clinical psychologists should be certified by their own group rather than be licensed.

**2. Recommendations concerning the epileptic, substitution of the word "certification" for the word "commitment" wherever it appears in the statutes, use of the term "mental disease" instead of "mental illness," presumption of incompetency, jury trials for determining whether a person is mentally diseased, temporary detention and custody, and fees are to be turned over to the Committee on Public Policy for implementation in the 1955 legislative session.**

3. Development of special facilities in hospitals for disturbed children should be stimulated, and treatment programs should be developed for them at both northern and southern hospitals for exceptional children.

**4. An interpretive manual on the handling of disturbed children should be developed for the use of judges.**

**5. A manual should be developed to assist the director of mental hygiene of the Department of Public Welfare in working with medical directors of county hospitals.**

6. A special study group should be created to evaluate the problems of alcoholism and give medical guidance where indicated.

### Public Assistance

The Division of Public Assistance under the chairmanship of Dr. H. W. Carey, Lancaster, issued a report indicating that progress is being made on the development of a fee schedule that can be the basis of negotiation between welfare departments and county medical societies.

### Rehabilitation

The Division on Rehabilitation, Dr. Ray Piaskoski, Milwaukee, chairman, reports that it was instrumental in getting the State Board of Vocational and Adult Education to adopt the Blue Shield "A" fee schedule as its schedule for surgical services provided under rehabilitation laws. The division is also discussing the matter of medical consultation in district and local rehabilitation offices.

### School Health

The development of conferences on school health has proved very successful, the House of Delegates told the Division on School Health, whose chairman is Dr. E. H. Pawsat, Fond du Lac. More than 400 persons attended two conferences at Eau Claire and Oshkosh.

**Another conference is scheduled for Stevens Point on October 20 and future conferences may be developed at Milwaukee, Superior, Platteville or Whitewater during the coming year.**

The House also urged that the Division continue to cooperate with

PAST PRESIDENTS MEET during the Annual Meeting. Left to right around the table are: K. H. Doege, Marshfield (1949); A. H. Heidner, West Bend (1952); guest Frank Kuehl, legal advisor for the American Medical Association's Washington Office; R. G. Arveson, Frederic (1940); H. Kent Tenney, Madison (1954); S. E. Gavin, Fond du Lac (1937); J. C. Sargent, Milwaukee, deceased (1938); Charles Fidler, Milwaukee (1945); R. P. Sproule, Milwaukee (1941); A. J. McCarey, Green Bay, current president; and M. A. McGarty, La Crosse (1921).

the Wisconsin Interscholastic Athletic Association so that all medical aspects of this program will be in line with sound medical practices and in the best interests of the children covered.

### Tuberculosis

The Division on Tuberculosis and Chest Diseases under the chairmanship of Dr. H. A. Anderson, Stevens Point, recommended that the mobile units of the State Board of Health continue their services for the detection of tuberculosis, further efforts should be made to set up workable programs so that all school personnel receive chest examinations as a condition of employment, and that steps be taken to provide better tuberculosis care for patients in mental institutions. The Division emphasized that there is no adequate substitute for institutional care of patients with tuberculosis. It discouraged home treatment of active tuberculosis. The Medical Society was asked to lend its support to the continued operation of the Douglas County Sanatorium for the Mentally Ill.

### Vision and Hearing

The Division on Visual and Hearing Defects proposed continued development of school screening programs to reveal hearing defects with special attention directed to referred cases so that the recommendations of the otologist can be carried out. Dr. Maxine Bennett, Madison, is chairman of the Division. The House of Delegates urged the Division to develop suitable standards for a visual screening program patterned after the hearing program. The Division was praised for its pamphlet entitled "Hearing Conservation Programs for Wisconsin Industries." Wisconsin is the first state society to develop such a guide. Nearly 5,000 copies have been distributed to industry thus far.

## *Praise Work in Industrial Health*

Milwaukee, Oct. 6.—Three-fourths of the membership of the medical society are now participating in the Workmen's Compensation Open Panel program, according to the report of the Council on Medical Services adopted by the House of Delegates.

Nearly 60,000 employers received the printed panels last year listing all members of the society who participate in the program.

The Council on Medical Services also proposed that:

1. All physicians be aware of the Placement Service of the society which can assist in locating general practitioners, specialists and locum tenens.
2. The society cooperate in any projects set up for the purpose of providing improved nursing services.

The Council is considering revision of the "Guide for Medical and Nursing Personnel," published in 1948 in cooperation with the Industrial Hygiene Unit of the State Board of Health.

## Urge Doctors to Buy "Today's Health"

Milwaukee, Oct. 6.—The Woman's Auxiliary to the State Medical Society of Wisconsin received the compliments of the House of Delegates for its contribution to public health through the promotion of *Today's Health.*

The delegates also urged every member of the State Medical Society to give "encouragement, cooperation and support" to the Auxiliary's campaign to place the magazine in every physician's office, school, public library and private home in Wisconsin.

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Our helpful brochure
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# REPORT DETAILS OF MATERNAL MORTALITY STUDY

## Full Report Available for Staff Meetings

**The following news release was issued by the State Medical Society concerning the results of a special study on maternal mortality. The complete report will be printed shortly in the Wisconsin Medical Journal.**

**Members of the Maternal Mortality Study Committee are available for county medical society and hospital staff meetings to discuss their findings. They have slides and charts to supplement the factual presentation. Contact members of the committee or the State Medical Society, 704 East Gorham Street, Madison 3.**

**The study covers a description of the program, autopsies, multiparity, hemorrhage (including discussions of ruptured uteri, ectopic pregnancies, hypofibrinogenemia), toxemia, cesarean section, anesthesia, and use of drugs.**

Milwaukee, Oct. 5.—Prospective parents received good news along with some words of advice as the State Medical Society revealed the results of a special study of maternal mortality in Wisconsin.

The survey covered 66 deaths of mothers in childbirth which occurred in Wisconsin during a period of 12 consecutive months.

The good news came from the fact that doctors are making new efforts to reduce Wisconsin's death rate among mothers in childbirth, already one of the lowest in the nation. The medical society reports that three steps have already been taken to improve doctors' care of difficult childbirth cases:

1. **An extensive state-wide postgraduate education program has been started to explain the results of the study to doctors attending hospital staff and county medical society meetings.**
2. **Plans are underway in cooperation with the American Red Cross and local blood banks to have fibrinogen, a blood derivative which overcomes the tendency to hemorrhage, available at key locations throughout the state. Until recently, fibrinogen has been available only in Milwaukee and Madison.**
3. **Efforts are underway to obtain an autopsy in every maternal death so that the true cause of death can be determined and used as a guide to prevent similar occurrences in the future.**

The good advice, coming from the same survey, shows how mothers-to-be can make childbirth safer for themselves. The survey revealed several deaths which resulted because the patient did not seek the attention of a physician until it was too late. In other deaths, the patient did not follow the physician's instructions.

### Hemorrhage Chief Cause

The report also revealed that nearly half of the 66 maternal deaths were caused because serious diseases such as diabetes and nephritis were aggravated by pregnancy.

The report stresses the necessity for early and thorough examination of the prospective mother to determine if she is physically fit for pregnancy.

**The study was made by a special committee of the Division on Maternal and Child Welfare of the Commission on State Departments of the State Medical Society. Dr. T. A. Leonard, Madison, serves as chairman. Other members are Drs. J. W. Harris, Madison; Alice D. Watts, Milwaukee; F. J. Hofmeister, Milwaukee; R. J. Sanderson, Beloit; and E. D. Wilkinson, West Allis.**

Of the deaths studied during the 12-month period, most occurred within the mid-childbearing years. Twenty-three of the 66 deaths were among women who had previously delivered one or more children, showing that these women "have no special protection conferred upon them" simply because they have previously had children.

**Hemorrhage was the most important cause of maternal death. The Study Committee believes that early recognition of danger signals by the pregnant woman, more universal availability of fibrinogen, readily available blood for transfusion and early recognition of conditions that lead to hemorrhage will do much to eliminate or reduce the deaths from this cause.**

In spite of everything that the physician may do to save the difficult childbirth cases, the Study Committee pointed out that there is "a residue of patients who do not seek medical attention until the course of illness is irreversible or who will not cooperate with the physician."

The committee expressed the hope that the findings will "suggest avenues through which some of the marginal deaths can be saved and Wisconsin's fine record even further improved."

**Dr. T. A. Leonard, Madison, (left) Study Committee Chairman, and Dr. R. F. Purtell, Milwaukee, Chairman, Division on Maternal and Child Welfare, under which the study was conducted.**

# Delegates Approve 5-Point Plan for Handling Emergency Calls

Milwaukee, Oct. 6.—The House of Delegates approved five steps to correct what it called one of medicine's "most significant public relations problems, the availability of medical care at all times, day or night."

The proposals were presented as part of a report of the State Medical Society's Council on Medical Service.

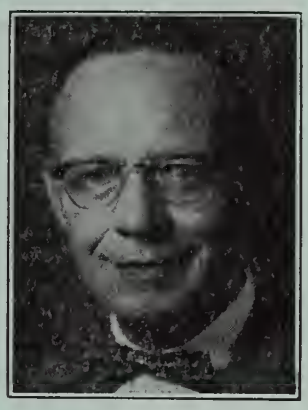
"Bitter reports of unsuccessful attempts to reach a physician in an emergency do not win friends for the profession," the society's Council on Medical Services told the delegates.

"Because the problem demands action that is swift and sure," the council made five recommendations which were later adopted:

1. **Wherever there is a general hospital, it should serve as the center for emergency medical services. Large cities were urged to follow the example of Milwaukee, Madison and Green Bay where formal telephone answering service bureaus have been set up.**
2. **In communities without hospitals, the police or telephone office should function as an "answering bureau" to locate a doctor.**
3. **A committee of doctors and laymen in every city should meet periodically to review emergency procedures and determine if they are effective.**
4. **Doctors should hold an open meeting once each year to explain to the public their procedures for handling emergency cases.**
5. **The State Medical Society will provide information and assistance to any county medical society or community seeking help in establishing an adequate emergency medical service plan.**

The council report pointed out the obligation of a physician to "respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service."

It made it clear, however, that the people should not think of the physician as "something like an electric current that is almost always available at the flick of a switch."



DR. DORCHESTER

**"Physicians are people, not the product of some law of physics," the report states. "Their services in times of emergency are not like those of the utility, available without a certain degree of participation on the part of the public."**

The report places some of the blame for inability to get doctors in an emergency on physicians who haven't done "enough joint planning so that the services of a portion of the medical population are always available."

But part of the blame belongs on the "people themselves who become frightened and hysterical and then unreasoning even when there is no emergency," the council reported.

Some of the problems arise, the report said, because civic leaders, family groups, and administrators of various institutions such as jails, haven't taken time to find out what to do in an emergency.

# SET SOCIETY DUES AT $60

Milwaukee, Oct. 6.—Dues for members of the State Medical Society of Wisconsin were established by the House of Delegates at $60 for 1955.

The reference committee considering the matter stated that it was "satisfied that the activities of the Society are being carried on with care and with close attention to detail."

# House Defers Decision on Section Delegates

## Approve Sections on Urology and Public Health

Milwaukee, Oct. 6.—The House of Delegates adopted several changes in the by-laws required by moving the date of the annual meeting from October to May. Under the newly adopted by-laws:

1. county society delegates to the annual meeting must be elected so that their terms expire at the end of each calendar year.
2. residency memberships may be granted for as long as five years.
3. the number of delegates to which each county society is entitled shall be based on the number of fully paid members at the close of the calendar year preceding the meeting of the House of Delegates in May.
4. the annual meeting of the Council may be held at some other time than during February.

The House also approved the establishment of sections in Urology and on Public Health. There has been controversy on this matter because of the feeling that Section delegates constitute dual representation in the House. A special study will be made during the next few months to determine how sections can be established in such a way as to avoid conflict with the legislative organization of the House of Delegates.

# *Praise Council on Scientific Work*

Milwaukee, Oct. 6.—The activities of the Council on Scientific Work "have given the members of the State Medical Society splendid opportunities to keep abreast of scientific developments," the House of Delegates said in accepting a report of the Reference Committee.

The Council's activities during the past year included 15 general scientific programs as part of the circuit teaching clinics, three hearing conservation clinics, one in-plant industrial health clinic, five cancer clinics for physicians and dentists, two conferences for physicians with school personnel at state colleges, and the annual meeting.

## State Needs Personnel to Boost Civil Defense

Milwaukee, Oct. 6.—"Nothing short of bombing will stimulate the public to interest in civil defense, and without the public the interest of the doctor cannot be sustained."

That was the picture portrayed by Dr. M. J. Musser, Madison, chairman of the Committee on Civil Defense, in a report adopted by the House of Delegates.

He reported that the Society's efforts to organize 100 mobile medical teams of 29 members each, including two physicians, have met with initial enthusiasm, but ended in disinterest.

The House therefore accepted the committee's recommendations that:

1. The Society should function only in an advisory capacity to the State Office of Civil Defense.
2. The Society should continue to have responsibility for assigning medical personnel to mobile medical teams and for training first aid personnel.
3. The State Office of Civil Defense should have an adequate corps of full-time personnel with no less than one full-time state employee assigned to mobile medical team development.
4. The same office should arrange adequate training programs and use every effort to interest the public in support of civil defense.

## URGE HOSPITAL BLOOD REGISTRY

Milwaukee, Oct. 6.—Blood programs in Wisconsin seem to be operating satisfactorily, the Committee on Blood Banks reported to the House of Delegates. Dr. W. D. Stovall, Madison, is chairman.

In some areas, however, there is misunderstanding of the Red Cross program and the availability of blood on a "loan" basis. The House urged physicians to discuss these matters with the directors of Red Cross blood centers in Madison or St. Paul, or with the Junior League Blood Center of Milwaukee.

Each hospital was urged to set up a registry of blood types of patients and possible donors to be ready for any emergency.

## Doctors Urged to Use SMS Veterans Agency

Milwaukee, Oct. 6.—The report of the Wisconsin Veterans Medical Service Agency, approved by the House of Delegates, urged all physicians and veterans to use this service so that local treatment can be administered whenever possible in the care of service-connected disabilities.

The home-town care program operated through this agency is primarily limited to home and office calls and laboratory procedures. Local hospitalization is authorized only in emergencies.

**Last year physicians were paid a total of $114,392 through the Agency for the care of veterans. The Operating Committee of the Agency, headed by Dr. J. S. Supernaw, Madison, has successfully negotiated with the VA to use the "A" surgical schedule of the Blue Shield plan as the basis of fees to be provided.**

## Public Policy Studies Cults in Wisconsin

Milwaukee, Oct. 6.—An important and exhaustive study embracing cult practices in Wisconsin is well underway, the Committee on Public Policy reported to the House of Delegates.

In a report adopted by the House, the committee said, "There are strong indications that practitioners in several of the cults are exceeding the limits of their respective licenses.

### Create Diploma Mills

**"There is evidence that several of the proprietary schools in which cultists are trained have abandoned cult teachings and are, in effect, the old medical diploma mills of the last century. Lip service is paid the standard medical subjects and texts; the names of Pasteur and Lister are heard in the halls, and the graduate openly invited to engage in medical practice for which he is neither trained nor educated."**

The committee reported that it has been able to find "no complete and permanent solution" to the critical shortage of medical personnel in state service, although continuing efforts are being made to improve the situation.

## OK Plan for Society Charitable Foundation

Milwaukee, Oct. 6.—A proposal to establish a Scientific, Educational, and Charitable Foundation of the State Medical Society was approved by the House of Delegates.

Proposed by the Council, the Foundation would create a single organization which could receive contributions from physicians and others and administer them according to the intention of the givers or in "the best judgment of the management of such a body."

### Wide Representation

It is contemplated that the Foundation will eventually absorb the Student Loan Fund, handle fund raising for the American Medical Education Foundation, conduct scientific, educational or economic research, handle studies such as the recent maternal mortality survey, and provide grants for disabled physicians.

**The Foundation will be governed by a Board of Trustees composed of the Council of the Society, and one representative elected by each county medical society. Annual contributions from the membership would be established by the House of Delegates and would be payable on a voluntary basis only. Physicians under 35 years of age would not be expected to contribute.**

Once the Foundation is under way, efforts will be made to secure grants from industry and other sources for specific studies.

## SAMA DELEGATES ATTEND MEETING

Milwaukee, Oct. 6.—Three representatives of local chapters of the Student American Medical Association attended sessions of the House of Delegates as observers.

Mr. Wayne Munson, Madison, attended as president of the Wisconsin Student Medical Association at the University of Wisconsin Medical School.

Representing the Student AMA chapter at the Marquette University School of Medicine were Mr. Robert G. Brault, and Mr. Fred G. Sehring, Milwaukee, president of the chapter.

# BLUE SHIELD REVEALS NEW PLANS FOR COVERAGE

## Propose Area Meetings on Health Insurance

Milwaukee, Oct. 6.—The progress of the prepayment plans is challenged by "certain inadequacies and by administrative problems," the Commission on Prepaid Plans of the State Medical Society reports to the House of Delegates.

The Commission spoke concerning the Blue Shield Plan of Wisconsin (Wisconsin Physicians Service) which it directs.

The major problems are:

1. **Non-group enrollment**
2. **Sale of broadened group benefits**
3. **Development of a deductible feature**
4. **Waiver of premiums during unemployment and disability**
5. **Study of "area premiums"**
6. **Public conferences for "grass roots" advice.**

Present non-group or individual enrollment is "hedged in with too many ifs," according to the Commission. "Each applicant is carefully screened in an effort to assure that he is not buying the contract to pay for planned care in the early future."

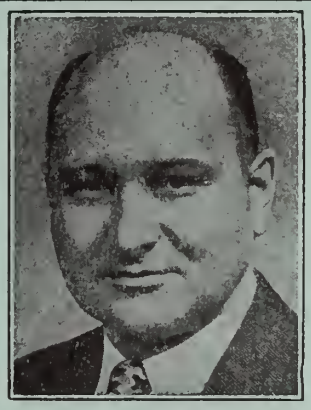
### Monthly Billings

The Commission said it proposes to study ways of providing Blue Shield benefits to "non-group enrollees" on the same conditions as those who get coverage on a group basis. It will also study ways of insuring the older age groups who now are not permitted to enroll.

**Purchasers of Blue Shield should also have the privilege of being billed monthly rather than quarterly as they are now. This would permit true budgeting by non-group subscribers.**

"Blue Shield of Wisconsin can be proud of its record of not having increased the cost of its program except on the one occasion when its benefits were increased," the Commission reported.

Purchase of several Blue Shield riders for infant surgical benefits and extended coverage "has not progressed satisfactorily to date," the report said. "To that end a small number of employees will be added whose primary purpose will be to improve existing contracts rather than to write new ones."



**DR. DESSLOCH**
**Chairman, Commission on Prepaid Plans**

Blue Shield has not included office or home medical calls in its coverage because it recognizes that "small infrequent charges for routine professional services are not really burdensome to the subscriber," according to the report.

**The House of Delegates was told that "coverage of minor claims is not good economics or good sense," especially because it costs Blue Shield about $3 to administer an average claim.**

"The Commission believes it would be a serious error for the voluntary prepaid health plans to neglect their obligation to educate the public to the consequences of trying to cover first dollars," the report declared. "It is much more important to cover the last dollars."

The Commission said it was beginning studies of means of offering contracts with varying deductible amounts, similar to automobile insurance.

**While the deductible feature offers several advantages to the policyholder, the Commission pointed out that it complicates the "full payment" principle by requiring the physician to look to the subscriber for the amount of the deductible.**

The Commission also announced its intention to explore more thoroughly a waiver of premium clause in Blue Shield contracts to provide coverage for subscribers in periods of unemployment or loss of wages caused by disability. Such a device, if perfected, would help the subscriber and the plan weather economic storms.

Another problem up for study by the Commission is the possibility of establishing premiums for medical-surgical coverage on an area basis based on physicians' charges and subscriber utilization in each area. Commercial insurance companies already do this.

To assist in the solution of the above problems as well as others, the Commission proposed that four or five area conferences should be arranged during the coming year at which the views of the housewife, farmer, laborer, educator, executive, government employee, and the various professions might be heard.

**It is proposed that the Blue Shield plan contribute "a sufficient sum to the University of Wisconsin to enable it to organize such a series of conferences."**

## Society Endorses Interprofessional Code

### Study Costs of Continuing Grievance Activities

Milwaukee, Oct. 6.—The Grievance Committee of the State Medical Society was commended by the House of Delegates for "its great activity and willingness to accept assignments in the field."

The House approved, in principle, an Interprofessionl Code developed by the Wisconsin Bar Association and the State Medical Society. The Bar Association was praised for its "splendid cooperation."

The code is set up as a guide to physicians and attorneys in the handling of expert medical testimony. When the code is approved in final form it will be made available to all physicians.

**The House gave special attention to the Grievance Committee's report concerning the costs of carrying out its activities. It was reported that these activities cost the Society about $7,000 last year, and had the work been done in further detail, it might have cost nearly $10,000.**

Specific details of costs will be reported to county societies and to the House of Delegates in advance of the 1955 meeting so that the problem of financing the committee's activities can be fully discussed.

# Reference Committee Members Have Hands Full at Meeting

Milwaukee, Oct. 6.—The 16 physicians who served on reference committees at the House of Delegates had a real job cut out for them. Their deliberations, covering a day and a half, produced 30 pages of printed reports for action by the House of Delegates.

**Serving on the Reference Committee on Report of Officers were: Drs. S. A. Morton, Milwaukee, chairman; W. D. Stovall, Jr., Brodhead; H. J. Kief, Fond du Lac; E. W. Humke, Chilton; and R. A. Thayer, Beloit.**

This Committee considered the general report of the Council, the statement on establishment of a scientific and charitable foundation, and reports of the president, president-elect, treasurer, secretary and American Medical Association delegates.

### 11 Others Serve

The following physicians served on the Reference Committee on Reports of Standing Committees:

**Drs. G. W. Carlson, Appleton, chairman; E. C. Cary, Reedsville; C. W. Stoops, Jr., Madison; C. A. H. Fortier, Milwaukee; and K. L. Bauman, Lancaster.**

This Committee considered the reports of the Society Committees on Blood Banks, Civil Defense, Military Medical Service, Cancer, Public Policy, Council on Medical Services, Council on Scientific Work, Veterans Medical Service Agency, Commission on State Departments, Maternal Mortality and future meetings of the State Medical Society.

**The Reference Committee on Resolutions and Amendments to the Constitution and By-Laws was made up of Drs. T. W. Tormey, Jr., Madison, chairman; J. A. Enright, Milwaukee; H. A. Aageson, Oconto; W. C. Henske, Chippewa Falls; E. D. Sorenson, Elkhorn; and J. D. Leahy, Park Falls.**

This Committee handled resolutions, uniform expiration date of delegates' terms, length of resident membership, a new date for delegate apportionment, the Annual Meeting of the Council, report of the Grievance Committee, Commission on Prepaid Plans, resolutions on the creation of Sections on Urology and Public Health and supplementary reports by the president and the secretary.

MRS. PEARSON

## AUXILIARY RAISES $3,765 FOR NURSES

Milwaukee, Oct. 6.—Mrs. C. R. Pearson, Baraboo, past president of the Woman's Auxiliary to the State Medical Society reported that the Auxiliary made 23 scholarships and loans to student nurses totalling $3,765.

"Without a doubt the piece de resistance of the Auxiliary's work these past few years has been nurse recruitment," she said. "Hospital tours, movies and school speeches are used to teach high school girls and boys about the possibilities of careers in nursing," she explained. "In addition, the Auxiliary has organized twelve Future Nurse Clubs to help students decide if nursing is the right field for them."

Mrs. Pearson reported also that the Auxiliary members raised $1,000 for the American Medical Education Foundation, assisted with civil defense planning, distributed *Today's Health* magazine, assisted the Society's medical history project, aided mental health units, and participated in numerous civic activities.

Twelve more counties have established county auxiliary units since last year, she said.

Mrs. Pearson added that Auxiliary members had also aided in projects in their own communities such as the Red Cross Blood Bank, tuberculosis mobile unit examinations, and others. She said members had done all they could to promote "good public relations in our own home towns."

## Surgical Society Gives $1,000 to Wisconsin Student Loan Fund

Milwaukee, Oct. 6.—The Wisconsin Surgical Society has contributed $1,000 to the Student Loan Fund of the State Medical Society.

Dr. F. L. Weston, Madison, medical society treasurer, made the announcement in reporting that the Student Loan Fund currently totals nearly $14,000.

**Eight medical students, four each at Marquette University School of Medicine and the University of Wisconsin Medical School, have received loans totalling $5,800.**

In his address to the House of Delegates, Dr. A. J. McCarey, Green Bay, president of the State Medical Society, urged greater giving by physicians to the Student Loan Fund. "We are trying to build this fund to such proportions that would permit loans to many more deserving medical students," he declared. "These loans they badly need to finish their education."

## Report on Society's Financial Condition

Milwaukee, Oct. 6.—The net worth of the State Medical Society on December 31, 1953, was $168,311.78, according to the Treasurer's Report submitted to the House of Delegates by Dr. F. L. Weston, Madison.

During 1953 the Society had a net excess of income over expense of $6,539.51, he reported. Income during the year totalled $229,236.39 while expenses totalled $222,696.88.

The report showed that the Society's net worth increased by more than $8,000 over 1952.

## 2,942 ATTEND ANNUAL MEETING

Milwaukee, Oct. 6.—Attendance at the annual meeting, October 4–6, reached an all-time high of 2,942 persons.

A total of 1,439 members of the State Medical Society attended the annual meeting. In addition, there were nearly 300 visiting physicians and more than 1,200 exhibitors, medical students, nurses, and physicians' wives who registered.

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# Message to the House of Delegates*

By A. J. McCAREY, M. D.
Green Bay

EACH year we convene in this great metropolis of Wisconsin and go through a process of reviewing what we have accomplished in the past and of planning what we must do in the years ahead and how we are going to do it.

Because of the nature of the work which you have chosen me to do, it has been my privilege, as also my obligation, to examine quite carefully this past year practically every activity of this Society.

I have tried to measure these activities, wondering if they are carrying out the purposes for which this organization was founded over a century ago. Wisconsin was still a territory when the pioneer physicians of that day joined themselves together for the following purposes:

"To cultivate harmony and kind feelings amongst the members of our profession, to promote the advancement of the medical and collateral sciences, to assist us in acquiring a knowledge of the same, and, in keeping pace with the progress of medical science, to help us appreciate the nature and magnitude of the mutual duties and responsibilities existing between the medical profession and the community, and to protect ourselves and society against the impositions of medical pretenders, we physicians and surgeons associate ourselves together."

The pioneer physicians of those early days traveled to their meetings in horse-drawn vehicles, perhaps on horseback, or, at best, in the crude railway equipment of that time. Today we come in shiny automobiles over concrete highways, in modern streamliners, or in the graceful ships that fly the air lanes.

We hold our meetings in a spacious auditorium and in a twenty-story hotel in a city rapidly approaching a million in population.

Wisconsin's growth, the increasing complexity of our civilization, the forces that are threatening to destroy our free institutions have increased our problems enormously. This Society, therefore, has, of necessity, gradually developed a larger and departmentalized staff at our headquarters. Our executive secretary, although a member of another profession, is dedicating his life to the cause of medicine. He has selected and trained men of intelligence and ability to help him. He has inspired them, by his example, with great devotion to the cause they serve.

Not a month goes by but that the doctors elected by us as our representatives meet and discuss and evaluate and plan, and sometimes even argue a bit, in order that the purposes of this organization may be fulfilled, its functions may be constantly supervised, and its responsibilities properly carried out.

I wish to mention a particular duty of those of us who have been elected as officers, councilors, and delegates that does not seem to be sufficiently recognized. It is because our fellow members back home had confidence in us that we were chosen to represent them. We must, therefore, go back to our county societies and explain to them the many problems we are trying to solve and the decisions that we make in regard to them. If there is some lack of interest by our members throughout the state, it may be due, partly at least, to the fact that we have not adequately taken them into our confidence nor made them realize that we need their advice and counsel. The members of our committees, who are in session frequently to study and recommend solutions of the problems arising in the various areas we have

* Presented before the House of Delegates, One Hundred Thirteenth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, October 4, 1954.

assigned to them, can also help us in effecting this much-needed liaison.

The scientific programs at these annual meetings and our postgraduate programs throughout the state make it possible for us to amply fulfill our obligation "to promote the advancement of medical science and to help our members acquire a knowledge of the same." This much, then, for an analysis of our Society as an organization.

I wish this morning to give some thought also to ourselves as the individuals who are joined together in this Society. It is as individuals that we conduct most of our public relations. It is how we think and act as individual doctors that we create either ill will or good will for ourselves and for our profession.

Let us dwell for a moment on how the medical profession developed. It has been said that the development of medicine rests primarily on man's sympathy for man. The desire to be relieved of pain and disability represents a reaction based on the powerful instinct of self-preservation. But the desire to relieve pain and disability in others represents a reaction based on love.

In centuries gone by, the patient men in the monasteries of western Europe transcribed and preserved for posterity valuable treatises on medicine. As they did so, they also taught that the care of the sick is a task of love and mercy.

Through the years that followed, this has been the underlying philosophy of those who, as a profession, have practiced the art of healing. Its re-emphasis from time to time might be a help to us in solving our many problems and in fulfilling our many responsibilities, both as individuals and as a medical organization.

Let me mention only a few of these. There is the Blue Shield movement in Wisconsin. It is without question one of the most outstanding enterprises ever undertaken by us. It is a sincere attempt on our part to make it easier for Wisconsin citizens to protect themselves against the cost of sickness and injury. Wisconsin doctors feel very strongly that, if the quality of medical care is to be protected, it is the direct responsibility of the medical profession to pilot the course of this new ship they have launched and which is still sailing through more or less uncharted seas. More cooperation and participation by Wisconsin doctors would help greatly in this undertaking.

There are the medical schools that educated us at a cost far exceeding the amount of tuition we were able to pay them as medical students. I know how generously many of our Wisconsin doctors have donated to them. But Wisconsin's contribution to the American Medical Education Foundation has not yet measured up to what we all know Wisconsin can do in this direction.

There is the Student Loan Fund of our State Medical Society. We are trying to build this fund to proportions that would permit loans to many more deserving medical students. These loans they badly need to finish their education.

In every Wisconsin community the wisdom and the judgment of doctors of medicine would be gladly welcomed in many civic enterprises, especially in the field of health and welfare. I repeat, these are but a few of our many responsibilities.

At the outset I spoke about those pioneer physicians who founded this Society and the reasons for which they did so. I like to believe that the spirits of these men are still with us at each of these annual meetings, that somehow from some celestial rampart they look down upon our deliberations. I wonder if they are fearful that, practicing as we are in this modern, scientific, materialistic world, we may be placing insufficient emphasis on the spiritual and humanitarian concepts that have made our field of endeavor different from most others and have made ours a profession dedicated above all else to the service of humanity.

In these troubled times, we must realize more than ever that the continued welfare of our profession depends on our integrity and our moral responsibility to our patients just as much as on training and ability or any other similar attributes that we feel it is necessary for a good physician or surgeon to possess.

Occasionally there is one among us who may falter, who may disregard the ethics of the profession he has chosen and to which he has been given the privilege to belong. In regard to those who practice unethical medicine, Dr. Walter B. Martin, President of the American Medical Association, in the House of Delegates last June at San Francisco spoke as follows: "The medical profession

has a particular responsibility in reference to self-discipline. As a learned profession, we are permitted to judge ourselves and each other. It is difficult for others to judge us since it is only our brother physicians who can determine our competency and often our motives. The responsibility is not only on each of us as individuals, but is also a concern of our organized groups, hospital staffs, local and state societies, and the American Medical Association."

In closing this report of a year's study to which you assigned me, may I state, then, that I believe that those who walked this way before us would approve of the way we have conducted the affairs of the organization which they founded so many, many years ago. Following in their footsteps, we shall continue to direct our Society and ourselves along the path of truth, righteousness, and devoted service to our fellow men and thus continue to earn for our profession the blessing of The Great Physician Himself, for it has been written, "Inasmuch as ye have done it unto one of the least of My brethren, ye have done it unto Me."

## ANNUAL CONGRESS ON OBSTETRICS AND GYNECOLOGY, DECEMBER 13–17

The sixth American Congress on Obstetrics and Gynecology will be held at the Palmer House, Chicago, December 13–17. The five-day meeting is sponsored by the American Committee on Maternal Welfare, Inc., and the American Academy of Obstetrics and Gynecology.

Designed for physicians, nurses, public health officials, and hospital administrators concerned with mother and baby care, the program will include approximately 30 formal papers, 22 symposia and panels, luncheon discussion groups, and round-table discussions. Scientific and technical exhibits will present the latest developments in the field.

Among the panel topics will be:

"Indications for Hysterectomy"
"Factors Determining Type of Cesarean Section"
"Function of Personnel and Standards of Procedure in the Delivery Room"
"Management of Prolonged Labor"
"Blood Transfusions"
"Preparation for Parenthood"
"Consultation in Obstetrics"
"Community Aspects of the Care of the Cancer Patient"
"Obstetric Anesthesia"
"Selection, Training, and Function of Obstetric Personnel"
"Perinatal Mortality"
"Organization and Operation of Maternal Mortality Committees"
"Lesions to be Considered in the Differential Diagnosis of Carcinoma of the Cervix"
"Carcinoma of the Cervix"
"Toxemias of Pregnancy"
"Obstetric Hemorrhage"
"Prenatal Care"

Symposia subjects will include: "Medical Complications of Pregnancy," "Accreditation of Hospitals and Residencies," "Basic and Graduate Education and Training of Obstetric Nurses and Supervisors," "Premarital Examinations and Counseling," and "Prevention and Management of Prematurity."

# Idiopathic Myocarditis in Infants and Children*

By WILLIAM H. LIPMAN, M. D.
Kenosha

THIS is the case of a 20-month-old female who was first seen on October 31, 1953. Two weeks before, in Denver, Colorado, the infant developed a "cold" and was treated with an injection of penicillin. She apparently recovered from this infection promptly, appeared well and playful, and ate normally. She was able to make the automobile trip from Denver to Kenosha uneventfully. A few days prior to entrance into the hospital, the child became listless, apathetic, and anorectic. She became pale and suddenly began to cough and to breathe rapidly; she could sleep without coughing only when held upright. The mother stated that she seemed a little blue at times. The infant was afebrile, cool, clammy, and restless. She tried to walk but seemed listless and asked to be held. Her face and abdomen were puffy the few days prior to hospitalization.

The infant was a normal, well-developed baby at birth and had normal growth and development, with only an occasional upper respiratory infection and none of the childhood exanthemata. Three siblings were living and well. One brother had hay fever, and the mother noticed that the patient sneezed considerably prior to this illness. On examination her skin was pale, her lips and nails were slightly cyanotic, the respirations were about 86 per minute, and the pulse rate was 172 per minute. The conjunctivae and mucous membranes were pale; the lips were parched. The throat was normal. The face was puffy, and the skin had a lemon yellow tinge. Cardiac dullness extended to the left axilla. Murmurs were not present. Many moist and crepitant rales were heard over the entire chest. The abdomen was distended, and ascites was present. The liver and spleen were not felt. There was no ankle or sacral edema. Her erythrocyte count was 3,300,000; white blood cell count, 8,600; hemoglobin, 8.0 Gm. She had 40 segmented neutrophils, 57 lymphocytes, and 3 stabs. Other laboratory findings, including sedimentation rate, were normal. A single blood culture was negative. The throat and nose cultures grew only staphylococci. In the x-ray of the chest on the day of admission, October 31, the heart shadow was considerably enlarged; and fanning of the pulmonary markings outward from both hilar areas, indicative of pulmonary vascular congestion, was seen.

Fig. 1—Chest film taken on October 31, 1953. Note the widened cardiac shadow and the fanning of the pulmonary markings.

The infant was given oxygen, digitalis, Mercuhydrin, small doses of ACTH, mild sedatives, vitamins, and antibiotics. Three whole blood transfusions of 100 cc. each were given at weekly intervals. The rectal temperatures ranged from 99.6 F. to 101.2 F. The pulse varied from 120 to 170 beats per minute, the respiratory rate from 52 to 90 per minute. Mild secondary anemia recurred within several days after each blood transfusion until the third week in the hospital, when the red blood cell count remained over 4,500,000 and the hemoglobin over 12.5 Gm. On two occasions, the urine contained an occasional red blood cell, and once it contained a trace of albumen.

* Presented before the Wisconsin Heart Association on June 5, 1954, at the University of Wisconsin, Madison.

The diagnosis of nonspecific myocarditis with congestive failure was made. It was felt that congenital heart disease, pericarditis, and valvular heart disease could be ruled out. Other diagnostic possibilities were endocardial fibroelastosis and myxedema heart.

Improvement did not begin until the third week. Then the patient was transferred to a Chicago hospital. The diagnosis, based chiefly on the changing appearance of the electrocardiograms, was myocarditis of virus origin. The physician under whose care the child was placed considered idiopathic hypertrophy a remote possibility.

Upon the patient's return to Kenosha on December 6, she was afebrile but still had a cough, nocturnal dyspnea, a pulse of 140, and a respiratory rate of 50 to 60 per minute. She had been taking 30 mg. of digitalis leaf daily.

On December 13, 1953, seven weeks after onset of the illness, the infant was hospitalized again because of an acute upper respiratory infection, with a fever of 103.6 F., marked cough, dyspnea, cyanosis, and tachycardia. No murmurs were heard. Oxygen, antibiotics, digitalis, and mercurials were given. Recovery was gradual; and, on December 23, she was discharged. The respiratory rate was down to 45, the pulse rate down to 136; and the ascites had subsided.

When last seen on June 21, 1954, her chest was clear, her pulse rate 84, respiratory rate 22 to 24, and her blood picture normal. She had no heart murmurs and was otherwise symptom free. The chest plates and electrocardiographic tracings mark the progress of her course. (Figs. 1–6).

### Discussion

Myocarditis of unknown origin was first described by Fiedler; this occurred in an adult. Up to the present time, only about 100 cases of isolated myocarditis in infants and children are recorded in the literature.

In their review of 97 cases of all types of myocarditis in children, Saphir, Wile, and Reingold[1] found only three with idiopathic myocarditis. They concluded that "such myocarditis may be present in apparently healthy individuals who suddenly develop progressive myocardial weakness and succumb quickly." They called this "isolated myocarditis." The outstanding symptoms and signs were tachycardia out of proportion to temperature, cyanosis, and cardiac enlargement. Flat or inverted T waves appeared in the three standard leads of the electrocardiogram.

In these enlarged hearts, hypertrophy of the muscle fibers was common; inflammatory, toxic, and degenerative changes also were seen. Endocarditis and pericarditis were rare. Although the myocardial lesions were identical with those seen in some of the infectious diseases, no clinical, pathologic, or bacteriologic evidence of infection was found; and no changes that could be related to infection were found in other organs.

Williams, O'Reilly, and Williams[2] observed 14 children with idiopathic myocarditis in three years. They divided these into two groups; namely, the acute group of nine patients, ranging from 12 days to five years of age, and the subacute group of five patients, from 17 months to six years of age. Of the acute cases, two survived; of the subacute group, one survived.

The initial symptoms of the acute group were commonly mild: a slight fever, some

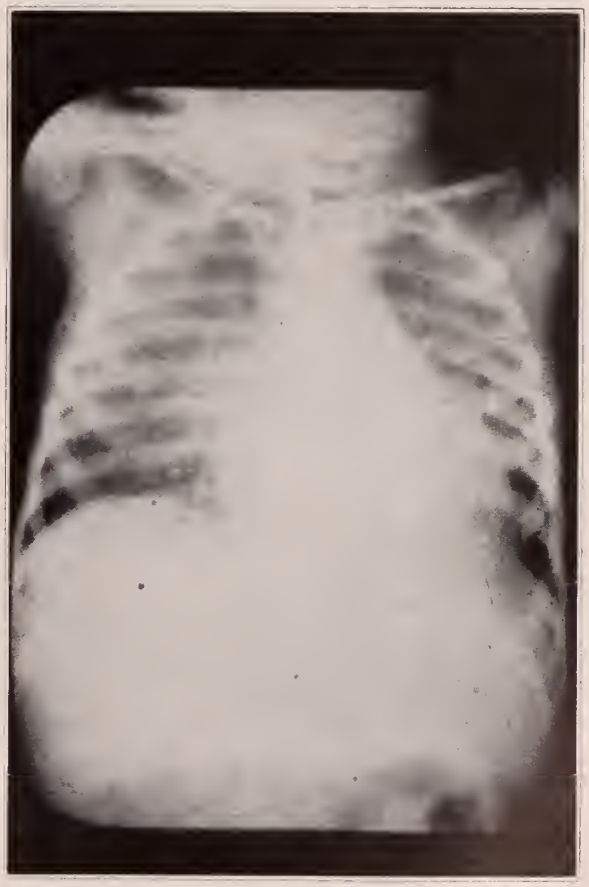

Fig. 2—Chest film taken on November 16, 1953. Size of cardiac shadow is unchanged. Pulmonary markings still show severe congestion.

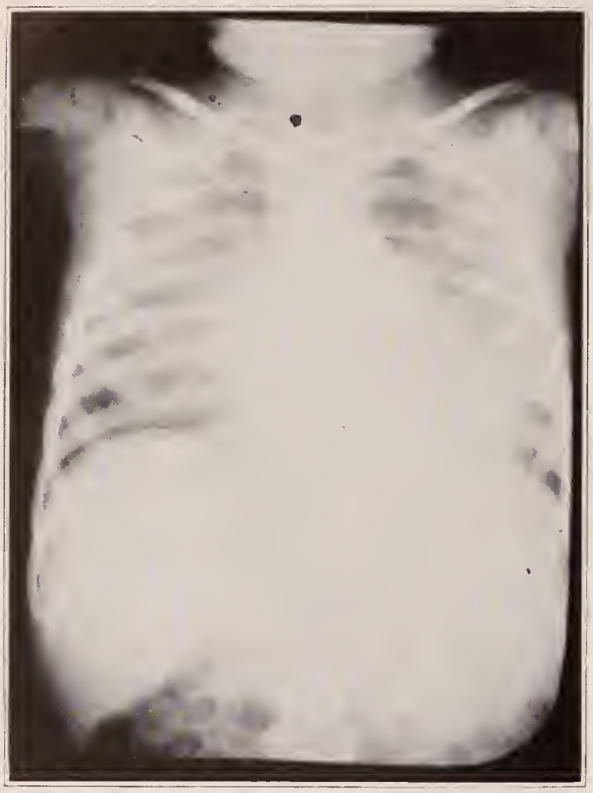

Fig. 3—Chest film taken on December 14, 1953. Note slight decrease in size of cardiac shadow.

Fig. 4—Chest film taken on April 27, 1954. Note almost normal size of heart shadow and clearing of the lung pathology.

irritability, some mild vomiting or diarrhea, or a mild rhinitis or sore throat coming on a few days before serious circulatory or respiratory manifestations ensued. Pallor; restlessness; cold and clammy skin; subnormal or slightly elevated temperatures; a rapid pulse of 150 to 170 per minute; and rapid, grunty, or wheezy respirations as high as 90 to 100 per minute were present. Physical findings suggesting pneumonia were noted. Heart sounds were poor, and liver enlargement was present. Subcutaneous edema was present in only two patients; and, in three patients, the urine contained a trace of albumen but no red cells or casts.

Radiological examination of the chests in the acute group showed gross uniform cardiac enlargement, but the lung fields were not congested. Several had bilateral pleural effusions. Low voltage Q–R–S complexes, especially in Lead I, and inverted T waves in all three standard leads were seen in the electrocardiograms.

Autopsy showed dilated hearts with thicker than normal walls, flabby heart muscles, and reddish or pale streaking of the muscle wall. The pericardium, endocardium, and valves were all normal. Microscopic examination revealed widespread, patchy, interstitial edema; leukocytic infiltration; and myocardial degeneration.

In the subacute and chronic group of the Williams[2] series, the prodromal symptoms were gradual and insidious before cardiac failure developed. Constant symptoms were vomiting, rapid grunting respirations, pallor, cyanosis, and edema. Physical signs were cardiac enlargement; tachycardia; gallop rhythm; liver enlargement; and, by contrast, signs of pulmonary congestion. X-ray findings revealed gross but symmetrical cardiac enlargement, congested lung fields, and often small bilateral effusions. Electrocardiograms were the same as those in the acute type.

All responded to digitalis therapy but relapsed following its cessation. All had cardiac damage, and two patients had evidence of mitral valvular disease. In our patients and in those described in the literature, mild to severe upper respiratory infections preceded the cardiac symptoms. Only four of Williams' patients had evidence of previous infection.

Identical myocardial lesions have been found associated with many different infections. Diphtheria, poliomyelitis, and measles

are the most common diseases of infancy where myocarditis has been found; but it occurs occasionally in almost every infection. This syndrome has occurred in adults, but it is much more rare than in infants and children.

Myocarditis in infants and children is rarely diagnosed clinically because it is uncommon and because cardiac failure in a young infant usually is not recognized unless it has been previously encountered. Furthermore, a severe respiratory infection can produce the same clinical picture. Pericarditis can be excluded by the pulsus paradoxus, friction rub, x-ray and laboratory findings, and the signs of inflammation. Congenital heart disease can be excluded by the sudden onset and the physical, x-ray, and electrocardiographic findings. Valvular heart disease produces local rather than generalized cardiac enlargement. Endocardial fibroelastosis is a very rare entity occurring in early infancy; the heart failure is usually sudden and rapidly fatal. Murmurs may be present, but the x-ray findings of marked left auricular enlargement may be pathognomonic. Diagnosis in this disease usually is made at autopsy.

Idiopathic myocarditis probably is an allergic condition. The initial manifestations are those of a mild upper respiratory infection. The myocardium becomes the shock organ, sensitized by the toxic products of bacteria, viruses, or chemicals. The diffuse muscle swelling, with the interstitial infiltration of leukocytes, large numbers of which are eosinophils, both beneath the endocardium and in the myocardium, or fibrinoid degeneration of interstitial tissues are the lesions of an antigen-antibody reaction. Sensitivity to penicillin in our patient may have caused some of the myocardial damage.

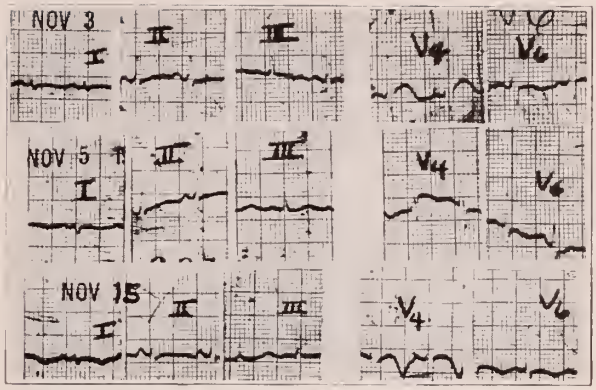


Fig. 5.

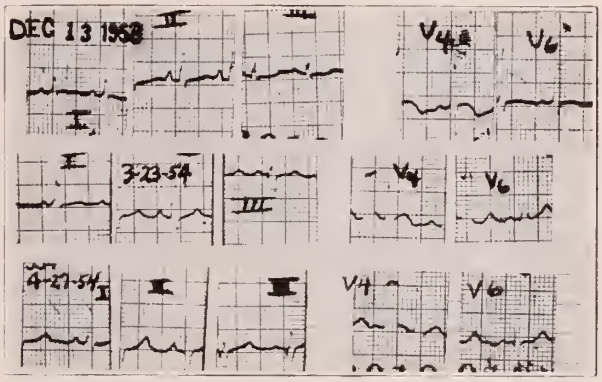


Fig. 6—Note the gradual improvement in the Q-R-S complexes and the involution toward normal of the T waves.

Antibiotics should not be used indiscriminately in the presence of myocarditis.[3]

625 57th Street.

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## STATE BOARD OF MEDICAL EXAMINERS ANNUAL MEETING

The regular annual meeting of the State Board of Medical Examiners will be held on January 11–13, 1955, at the Loraine Hotel, Madison.

At that time the board will consider applications for license to practice medicine and surgery in Wisconsin by written examination and by reciprocity. The last filing date for applications will be December 28, 1954.

# Fiedler's Myocarditis at Age of Two Months

By N. A. McGREANE, M. D.
Darlington

THIS paper reports a case of Fiedler's myocarditis, also described as acute isolated diffuse myocarditis and acute isolated interstitial myocarditis, in a two-month-old female child.

Fiedler gave the first clear account of the disease. It involves the myocardium alone and does not affect the pericardium, endocardium, or heart valves.

Since then, numerous reports have been made of cases proved by autopsy.

A review of these shows: 1. the etiology is still undetermined, even though some authors have associated the condition with numerous other diseases and chemical irritations; 2. it attacks all ages; and 3. its course may be rapid or prolonged—from one day to months.

We review this case because of the early age of the patient and the rapid course of the disease.

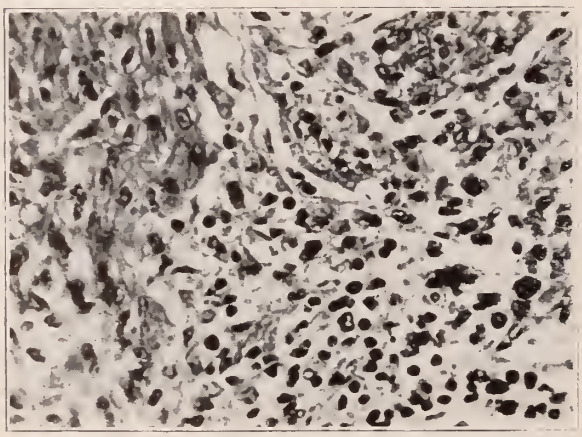

Fig. 1—Granulomatous lesion showing Aschoff-like cells and infiltration with plasma cells, lymphocytes, and an occasional polymorphonuclear cell.

## Report of a Case

**History:** B. S., a two-month-old female infant, was admitted to the Lafayette County Memorial Hospital on July 30, 1953, at 5:30 p. m. Three days prior to admission the child had vomited on several occasions but subsequently appeared well until the afternoon of admission, when she became acutely ill.

The child was listless and dyspneic, with a grunting respiration. The skin was cold, mottled, and cyanotic. The rectal temperature was 98.4 F.; the pulse was not palpable. The heart rate was over 160. No murmurs could be distinguished. There were numerous rales over the right lung field and a few in the left base posteriorly.

Evidence of consolidation of the right lung was seen on an x-ray. Her erythrocyte count was 3,300,000; hemoglobin, 9.8 Gm.; white blood cell count, 40,400. She had basophils, 1; eosinophils, 5; myelocytes, 2; juveniles, 4 per cent; stabs, 15 per cent; segmented forms, 42 per cent; lymphocytes, 27 per cent; and monocytes, 4 per cent.

A diagnosis of pneumonitis was made, and the infant was placed in the oxygen tent and routine therapy instigated. Some improvement in circulation was noted during the first hour, but death occurred at 2:00 a. m. on July 31.

On gross pathological examination, the abdominal cavity and its contents appeared normal. The pleural cavities each contained about 50 cc. of clear yellow fluid. Sections of the right lung were patchy yellow and appeared consolidated. The left lung was normal both externally and on section. The heart was slightly enlarged, weighing 30 Gm. (normal for this age is 23 Gm.) The myocardium was pale and edematous, while the valve leaflets were devoid of vegetation.

**Microscopic Examination:** (Dr. Lester McGary)

*Lungs:* Pneumonia characterized by pronounced pulmonary edema, developing hyaline membrane in air sacs, and hyaline thrombi in the pulmonary arterioles, as well as some proliferation of the small vessels, were seen. Interstitial edema also was present.

*Heart:* Microscopically, the lesion of the heart was that of a diffuse granulomatous myocarditis, with cellular infiltrate of lymphocytes, plasma cells, and a small number of polymorphonuclear neutrophils and eosinophils. Multinucleated giant cells resembling Aschoff cells, as well as perivascular cell bodies having somewhat the appearance of

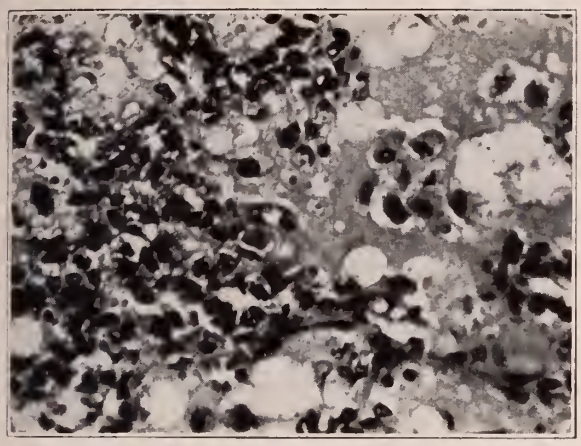

Fig. 2—High-power field of lung showing pulmonary edema and large mononuclear cells in the air sacs.

Aschoff bodies, and Anitschkow myocytes were found in many of the granulomatous lesions. There was a degeneration of some of the myocardial fibers, with a replacement of granulomatous tissue.

*Anatomical diagnosis:* Fiedler's myocarditis.

### Review of the Literature

In 1929, Scott and Saphir[1] reported 30 cases; the youngest was three years old.

Maslow and Lederer[2] reported a case in a child 19 months of age.

In 1938, Smith and Stephens[3] reported 6 cases—2 in infants of ages 10 months and 13 months—in which the disease was fulminating and death occurred within a short time.

In 1939, Helwig and Wilhelmy[4] reported 3 cases (ages 32, 43, and 13), in which death occurred suddenly with no previous symptoms or history of heart disease.

In an analysis of autopsy material from 5,626 cases, Saphir[5-7] found 240 cases of myocarditis, 15 of which were Fiedler's myocarditis.

House[8] reported 4 cases in infants in 1948; the infants' ages were 3 weeks, 13 months, 11 months, and 12 months.

Jones and Marshall,[9] in 1948, reported a case in an eleven-month-old infant.

114 Ann Street.

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## FILM ON CLEFT PALATE CHILD AVAILABLE

A new movie, "The Wisconsin Cleft Palate Story," in sound and color, has been produced by the Bureau for Handicapped Children, Department of Public Instruction, in cooperation with the University of Wisconsin Medical School, Department of Speech, and University Hospitals. It shows the integration of services necessary in the habilitation of a cleft palate child. This 36-minute film tells the story effectively and honestly.

The film can be rented from the Bureau of Visual Instruction, University of Wisconsin, 1323 West Johnson Street, Madison, Wisconsin, for a nominal fee. It is available for purchase through the Photographic Laboratory, 1204 West Johnson Street, University of Wisconsin Extension Division, Madison, Wisconsin.

# Comments on Treatment

Editors—HARRY BECKMAN, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

## Piperazine as a Vermifuge for Roundworm Infestation

Piperazine is a rather simple synthetic heterocyclic substance, diethylenediamine, $NH \cdot CH_2CH_2 \cdot NH\ CH_2CH_2$ and was first introduced into medicine for the treatment of gout, since its solvent power for uric acid is rather similar to that of lithium salts. In spite of the fact that it was relatively nontoxic, it never gained popularity in the treatment of this disease.

French investigators, referred to by White and Standen,[1] were the first to report the use of piperazine in instances of threadworm or pinworm infestation. White and Standen established the effectiveness of two oral administrations of piperazine hexahydrate to children at a dose level of 100 to 250 mg. per kg., given in two divided doses per day for seven days. This treatment was followed by a rest period of one week, when another series of treatments was given. The drug is remarkably free from toxicity when used in the lower dosage ranges. With high doses, diarrhea may occur but ceases promptly on cessation of the treatment. In general, the effective dosage ranged from 50 to 75 mg. per kg. per day in divided doses (morning and night) for seven days. The lower of these doses is considered the minimal, while doses of 75 mg. per kg. or more per day generally were practically free from any sign of toxicity. Gentian violet, at a dosage of 11 mg. per year of life, in divided doses, caused abdominal pain in two of twenty patients and, in one, vomiting occurred; and this chemical obviously possessed marked staining properties.

In reference to infestation by the ascarides, White[2] cites reports by the French investigators, who studied several thousand cases, and reports three of his own cases in small children (ages, approximately 3, 4, and 5 years). Case 1 was treated by use of syrup of piperazine hydrate in a dose of 0.5 Gm. twice daily (68 mg. per kg. per day) for a period of ten days. On the second and third days he passed 34 dead worms, but none thereafter. Case 2 was infected with Ascaris as well as with threadworms. He received syrup of piperazine hydrate at the rate of 130 mg. per kg. per day for a period of seven days. Nine roundworms (Ascaris) were passed on the second day. After five or six days no ova of Ascaris were found, though there were a very few ova of whipworms. Case 3 had been treated with santonin but continued to pass ova of Ascaris. Piperazine hydrate was administered in a dosage of 81 mg. per kg. in two divided doses per day. He passed 11 Ascaris worms in one stool, but neither ova nor adults of this worm were found during the following month.

The author calls attention to the fact that piperazine is safer for the patient and more effective as a vermifuge against the ascarides than previously employed drugs such as santonin, oil of chenopodium, or tetrachloroethylene. Unfortunately, the whipworm does not appear to be very susceptible to this relatively harmless new vermifuge.

In the realm of the unexpected, or oddities, may be mentioned a method described in an article in *The Lancet*, by F. F. Talyzin from Moscow; in this method, oxygen gas is used as a vermifuge for ascarides or, as the writer says, in effect, as a vermicide.[3] The gas is administered by duodenal tube inserted into the stomach after an enema and before breakfast. Oxygen is administered under slight pressure during a period of ten to fifteen minutes. Borborygmi in the mid-abdomen indicate that the oxygen has reached the intestines. A sensation of fullness is also felt. The usual dose of gaseous oxygen is from 1 to 2 liters. The worms are said to be passed on the second or third day, and no larvae evolve from the ova in the intestines. At first thought the whole procedure seems preposterous, but possibly the worms thrive in the presumably oxygen-poor medium of the small intestine and hence may be unable to tolerate an atmosphere of high oxygen content. It is an interesting idea, to say the least.—A. L. TATUM, M.D.

*(References listed on page 590)*

# Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

## REPORT OF A CASE*

**Dr. Abe Sosman** (Resident in Internal Medicine): The patient, a 36-year-old white male, re-entered this hospital in August 1952 with the chief complaints of headache, generalized weakness, nausea, and vomiting. The patient's past history revealed that he was well until 1942. While in the Army, he sustained trauma to the skull when struck by a rifle butt. He was unconscious for a very short period.

Approximately six months later he noticed a gradual onset of weakness, easy fatigability, polydipsia, and polyuria. He also noticed a gradual loss of libido. He was discharged from the service because of these complaints and with a diagnosis of anxiety state. He was treated for two years by private physicians with thyroid medication. The diagnosis of diabetes insipidus, Addison's disease, was made prior to his first admission to this hospital in June 1945; and this diagnosis was substantiated at that time. The patient then noted a loss of body hair and that his skin had become a yellowish-tan color.

In 1950 he complained of scotomata, photophobia, and hyperacusis. The eye symptoms were progressive, with a definite narrowing of the visual fields bitemporally; and subsequently complete blindness occurred secondary to bilateral optic atrophy in 1947.

In 1951 he noted the onset of occasional frontal headaches which were not very severe at that time. In May 1952 he re-entered the hospital with the complaints of moderately severe constricting type of headache and some memory impairment. On this last admission the patient described these headaches as much more severe and associated with vomiting. He also appeared confused, and his memory was definitely impaired. He also stated that his weakness was more marked than ever before. The patient had received many different types of therapy, which included desoxycorticosterone acetate, sodium chloride, testosterone, Pitressin tannate, cortisone, thyroid extract, and also x-ray irradiation of the pituitary gland. The drugs gave the patient some symptomatic relief.

Fig. 1—Photograph of patient showing female distribution of genital hair.

Physical examination revealed a tall, well-developed, well-nourished white male who did not appear acutely ill. (Fig. 1) His blood

* From the Departments of Pathology, Veterans Administration Hospital, Wood, and Marquette University School of Medicine, Milwaukee: **Dr. Francis Millen**, neurologist, and **Dr. J. M. Lubitz**, pathologist.

pressure was 110/80. An eye examination revealed no evidence of papilledema, but gave the findings of bilateral optic atrophy. The lung fields were clear, and the heart examination revealed essentially normal findings. The genitalia revealed atrophic testicles bilaterally. There was a female distribution of the pubic hair, and the skin was soft and smooth and had a bronze-tinged color. The remainder of the physical examination was essentially within normal limits.

Laboratory studies revealed a hemoglobin of 12 Gm., with 3.7 million red blood cells and a sedimentation rate of 36 mm. per hour; electrolyte studies were essentially within normal limits. X-ray of the skull showed no demonstrable abnormality of the sella turcica. There was some questionable minimal posterior displacement of the pineal body. Electrocardiograms were within normal limits. The patient was placed on various medications in an effort to relieve some of the weakness; these attempts were unsuccessful. Periodically the patient complained of severe headaches. In the latter part of October, he had rather frequent episodes of collapse, which were followed by periods of confusion and also periods of projectile vomiting.

**Dr. Paul Miller** (Resident in Radiology). The patient had several routine skull examinations, all of which proved to be essentially negative for any bone pathology. The patient's sella was normal in width and depth and showed no erosion. Fortunately, he was one of the 50 per cent of individuals beyond the age of 20 who do have calcification in the pineal gland. In this particular patient, as was mentioned in the protocol, it was felt that there was questionable minimal posterior displacement of the pineal gland.

**Dr. J. M. Lubitz:** Did the x-ray department have any interpretation of these findings?

**Doctor Miller:** There is none given in the report, but I believe that Doctor Pfeffer felt that the findings were compatible with a lesion in the area of the midbrain.

**Dr. Francis Millen** (Neurologist): May I see the skull x-ray, please? I am looking at the x-ray of the skull film to reassure myself about the sella and its bony structure and any evidence of intracellular lesions and also about the pineal gland because of the statement that it was posteriorly out of position. I note that in 1950 an x-ray of the skull shows the pineal gland in approximately normal position. The pineal appears to be somewhat downwardly displaced, not particularly posteriorly though, and, more significantly, I note that the amount of calcification in this gland during the two-year interim period has not changed; in other words, it has not increased in amount. This helps us somewhat to immediately distinguish one particular tumor, the pinealoma. Now, therefore, before going on to the clinical evaluation of this particular case, I would like to ask a few questions.

First of all, was there a spinal fluid examination done; and if so, what did it show? It was normal. With any type of lesion of the central nervous system, it is important, of course, to have the fluid that bathes the brain as an index of study in order to determine whether or not there is any organic pathology in the brain.

Next, I would like to know whether or not the neurosurgeon at any time offered his assistance in doing air studies, either a pneumoencephalogram or a ventriculogram. These were never done.

Considering the type of treatment this patient had as we review the history, we see that he had been handled mostly by the endocrinologist in the hospital. It is only fair at this particular stage to say that with a patient with this type of history, symptoms, and findings, one needs to have the combined efforts of the internists, particularly those of the endocrinologist, along with those of the neurologist. The difficulty that is presented on a clinical basis and the laboratory basis involves two separate structures; namely, the central nervous system with its brain, more particularly the region of the third ventricle or the diencephalon, more particularly the hypothalamus itself, and also the pituitary gland. In order to differentiate between a lesion of the pituitary gland and a lesion in the brain or the third ventricle, we need to have the benefit of the endocrinologist's opinion and interpretation of some of the findings. However, in his absence we will do whatever we can to help localize and determine the nature of this particular lesion.

To begin, is the lesion in the brain in the first place? The patient is 36 years old and presents symptoms of a metabolic disorder. It is noted that a diagnosis of Addison's disease was made in the past. In Addison's disease, the lesion involves primarily the

adrenal gland. We know that many metabolic disorders can occur without any definite brain disorder of a primary nature.

To begin the history, this is a 36-year-old, healthy, white male who sustained trauma to the skull. I suppose if we ask any patient who has had something wrong with the head, particularly headaches, if he has ever had a blow to the head, we almost always get the history of some head injury in the past. In thinking about the case in question, we shouldn't overlook the possibility at any time that perhaps this individual did sustain some intracranial damage, particularly in the form of a hematoma, thrombosis, or a hemorrhage directly into the brain substance in the floor of the third ventricle. Against that likelihood is the fact that he had no particular complaints shortly after having sustained the trauma, and it was not until six months later that he began to complain of his primary problems; namely, those of gradual onset of weakness, easy fatigability, excessive thirst, and excessive passing of urine (polydipsia, polyuria) and also a decrease in sexual potency of libido. So I think that at the beginning we ought to say that there is a remote possibility of one particular type of lesion, some post-traumatic vascular disturbance in the area of the brain involved. We know from the history that there is a brain lesion because of the headaches, projectile vomiting, and the like. We know that the area involved is in the region of the diencephalon or on its floor, the hypothalamus.

Whether the lesion is in the pituitary gland instead of the hypothalamus is another story, and we will see whether or not we can determine this. Needless to say, the pituitary gland has such a close relationship to the hypothalamus (actually the posterior part of it is an extension through the tuber cinereum of the floor of the third ventricle of the hypothalamus) that any lesion affecting either that structure, the hypothalamus, or the pituitary body is apt to produce a change in either one or the other. The disease diabetes insipidus consists of the failure of the kidney to concentrate urine. It may be due to several causes. We presume in this case that centrally it is due to the lack of the antidiuretic hormones, and we know that these particular hormones are controlled by the hypothalamus. Diabetes insipidus can occur with lesions of the hypothalamus in the absence of pituitary disturbance. All the metabolic studies are, for the most part, negative; and the picture that was presented didn't particularly look like one of a pituitary lesion. Now, before we go further, we point to that part of the brain, the hypothalamus or base of the third ventricle, as the area that is involved.

What are the types of lesions we could see in that area? First of all, trauma does come into the picture. Another consideration is infections. Changes are commonly found following certain of the encephalitides, particularly the equine encephalitis. We not infrequently find in the epidemic encephalitis of von Economo, inflammatory changes in the hypothalamus and other areas and parts of the diencephalon. Thirdly, we find hypothalamic lesions in certain degenerative diseases like multiple sclerosis. Vascular degenerative changes are also found in chronic alcoholics who for a long time have been insulting their brain with avitaminosis as well as alcohol, producing small, well-defined, and definite lesions in the region of the hypothalamus and creating a clinical syndrome that we recognize in the chronic alcoholic. Finally, that particular area of the brain is also subject to tumor; and that tumor may be one of several types. Benign cysts are probably the most common type of tumor of the third ventricle. There are also angiomatous types of tumors. That particular part of the brain can be involved by another type of space-occupying lesion; namely, an aneurysm of the internal carotid artery or one of its immediate branches. I recall a case that I had seen a number of years ago; the patient had a long history of headaches, fainting spells, and the like thought to be due to an anxiety neurosis. Over a period of many years, the patient developed evidences of hypothalamic disturbance with all the characteristic findings. She finally died with a rupture of an aneurysm, and it was plain to see the chronic as well as the acute effects that the aneurysm had upon the floor of the third ventricle.

As to discussing the tumors of the third ventricle, I won't take Dr. Lubitz's job away from him. I will let him describe the different pathological types. I'll refer again to the pineal gland, which is on the posterior and dorsal aspects of the third ventricle. Certainly a pinealoma has to be considered, but I don't believe this patient had such because

of the absence of x-ray evidence of pineal gland involvement. The patient with a pinealoma shows a precocious type of sexual development for the most part; and he also shows, because of the proximity of the pineal gland to the quadrigeminal plate, an involvement of ocular muscles, producing paralysis of upward gaze. Very commonly seen, also, is involvement of some of the sensory fibers as they pass up through the superior peduncles. I am reminded again of a case of a 16-year-old boy who had the symptoms primarily of a pituitary type of tumor or a hypothalamic type of lesion and who subsequently died of a pinealoma. Occasionally, nature plays tricks on us; and a tumor, if it's loose enough, will drop down away from the quadrigeminal plate instead of pressing or growing into the superior and inferior colliculi. Therefore, while we cannot prove this patient had a pinealoma, we do not entirely exclude it.

As we follow the progress of this case, we note a long history and that's important. This illness had its onset in 1942 and continued until the patient's death in 1952, ten years later. The long progressive history rules against anything but a neoplasm or a tumor type of lesion.

There is one part of the symptomatology that I'm not quite sure about. I get the impression that this condition showed progression in the last years. On the other hand, the description is that episodes of "collapse" occurred. I'm not quite sure I know what the doctor means by that term. I hope he is not referring to a crisis of Addison's disease or some other type of metabolic crisis. But we can presume, with the headaches and the projectile type of vomiting, that the collapse is associated with loss of consciousness or some increase in the intracranial pressure. Again, a lesion in the third ventricle, by blocking off either the opening into the aqueduct or one of the lateral ventricles through the foramen Monro, can characteristically produce an episode of collapse with loss of consciousness and with projectile vomiting.

Now, the history in 1950 of scotomata and photophobia probably indicates that it is about eight years after onset of illness that the patient begins to have involvement of his ocular system. We say "ocular system" until we're sure whether the lesion involves the optic nerves or the radiations or pathways back of the chiasm. The finding sometime later of bilateral optic pallor or optic atrophy should suffice to assure us that there is a direct pressure upon the optic chiasm or the optic nerve. Optic nerve atrophy can occur not only with a tumor lesion in that area, but also with a thrombotic type of lesion; and it can occur with pressure from a dilated third ventricle itself. The bitemporal hemianopsia that we see in cases of third ventricle tumors and, for that matter, in craniopharyngiomas or tumors of the stalk of the pituitary, is caused by a lesion of the optic chiasm. These tumors do not directly compress the chiasm itself, but rather they exert pressure on the small blood vessels over the optic chiasm. It is the pulsating and beating of the blood vessel as it lies on the nerve and as it is being pressed by the tumor against the nerve chiasm that causes the destruction of nerve tissue. Soft tumor tissue pressing against the nerve very likely wouldn't be sufficient to produce the degree of nerve damage that we see in these chiasm lesions.

We note, also, that it is eight or nine years after onset before the patient begins to complain of headaches. A tumor in the third ventricle itself should cause headaches earlier than that. The patient should have an occlusion of some of the ventricular openings, either of the aqueduct or the foramen, to produce headaches if there are to be the metabolic changes that are described. Also, he should have had headaches before he began to develop such obvious signs of pressure as bilateral optic atrophy. If he had enough pressure to compress the optic chiasm, you would have expected that there would have been enough pressure for him to feel bitemporal headaches or headaches at the root of the nose, which is a common place for headaches arising from third ventricle tumors or, for that matter, tumors of the pituitary gland. We prefer to keep the lesion out of the pituitary gland if we can because of the lack of marked definite metabolic changes and the intactness of the sella turcica. But the onset of headaches so much later always reminds me that a tumor can be growing in the pituitary gland for many years and growing slowly without there being signs of headache. It can produce changes by reason of its compression on the pituitary cells, in either the anterior or posterior part of the pituitary; metabolism changes, temperature changes, water, electrolyte balance changes, sugar metabolic changes, and diabetes insip-

idus may be produced. As such a tumor begins to grow, it finally can't find enough room in that sella and then bursts out through the diaphragma sella, producing a headache syndrome or giving relief from previous headaches. But a headache coming on late in a case with third ventricle tumor is an unusual finding, particularly if the chiasm is then already involved. We note that by 1952 there are other evidences of increased intracranial pressure in the form of increasingly severe headaches of a severe constricting type, as well as deterioration of memory and mental confusion. All the symptoms point away from the cerebrum and its cortex and help us to avoid considering any of those lobes of the cerebrum as the area involved. The fact that there was no description of an homogeneous hemianopsia again rules against there being a temporal lobe type of lesion.

The neurologic examination of this patient, ten years after this lesion began, is almost entirely negative except for the disturbances as described, with the bilateral optic atrophy indicating a pressure lesion directly in the region of the optic chiasm. The functions of the hypothalamus are in regulating metabolic and autonomic mechanisms neuronally, not through hormones, but through nervous influence acting directly on the pituitary itself and on other structures. In this patient, the hair is soft and fine and lost throughout the body. We see that sort of thing with a hypothalamic type disturbance less often than with a tumor of the pituitary, unless it is associated with an adipose genital syndrome of the type caused by a pituitary lesion like the chromophobic adenoma pressing on the anterior part of the pituitary gland. The presence of atrophic testicles and the fine hair tends to rule against its being an adrenal type of lesion because the adrenal type lesion and the Cushing type of disorder, for example, usually produce hypertrichosis. The notes tell us that the skin is a bronze-tinged color, but they don't say that there are purplish striae present such as one sees in the Cushing's type of tumor. This syndrome is sometimes thought to be due to a primary tumor of the pituitary. Very likely the pituitary disturbance; that is, the clusters of and increase in basophilic cells that were described by the older pathologists, are due to a secondary effect in the pituitary of the primary tumor in the adrenal gland.

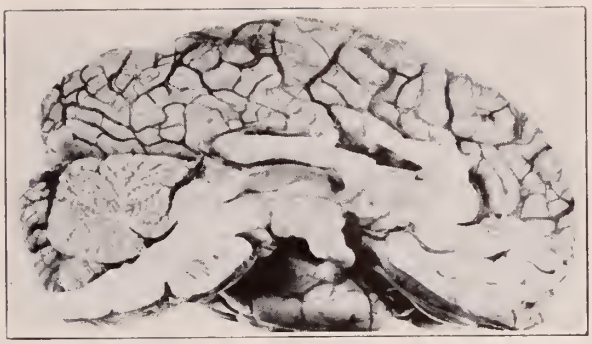

Fig. 2—Gross brain. The tumor originating in the pineal body extends to the quadrigeminal plate, the third ventricle, and the hypothalamic region.

Finally, I would have to say in summarizing this case that the evidence presented shows some slowly progressive lesions in the region of the third ventricle involving, either primarily or secondarily, the hypothalamus. Very likely the lesion is not in the pituitary body itself. My guess is that this patient had a slowly growing tumor involving the floor and substance of the third ventricle. The nature of such a tumor can only be guessed at preoperatively or before autopsy.

**Doctor Mace:** Could this be a craniopharyngioma according to the duration of the disease, and would there be calcification in that area due to this tumor?

**Doctor Millen:** Yes, I didn't go into the description as I mentioned, of all the tumors in this particular area, the pituitary tumors, the chromophilic adenoma, the chromophobic adenoma, the mixed type, and the Cushing's type. Of course, the stalk of the pituitary gland, the tuber cinereum, has its tumors, the so-called craniopharyngiomas. However, that type of tumor usually has calcium in it. I don't know what the incidence of calcification is, but it is high. I don't think one would be entitled to make the diagnosis of craniopharyngioma in the absence of calcification in the tumor.

**Doctor Lubitz** (Pathologist): The external examination has been depicted on the photograph. The only thing to add is the fact that the breasts were prominent and that the skin was dry. The lung showed slight edema and emphysema. The heart was small, 260 Gm., and was brown in color. The liver and spleen showed nothing remarkable. The adrenal glands were shrunken. The kidneys were not significantly altered. The prostate gland was small. The testes were small and lacked the usual stringiness. The most significant findings were in the brain (Fig. 2).

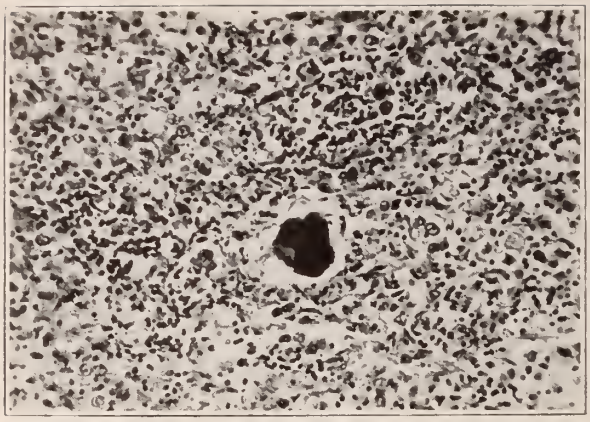

Fig. 3—Microphotograph, pineal body tumor (240 X). The tumor contains syncytial cells and small round cells. A spicule of calcium is shown.

There was a tumor involving the corpora quadrigemina, the third ventricle, and the hypothalamic region. The pineal body, which was enlarged and incorporated in the tumor, measured 12 x 8 mm. The pituitary gland was found, but it was reduced to the configuration of a dime because of the pressure of the tumor behind it. The problem was then to decide what type of tumor we had. The gross examination suggested an ependymoma because of the involvement of the ventricular system. Microscopically (Fig. 3), two types of cells were seen. There were large, eosinophilic, syncytial cells and small cells that looked like lymphocytes. The adrenal gland showed a very narrow cortex completely depleted of lipid content. This atrophy is obviously secondary to the hypothalamic involvement. In trying to find someone to discuss pineal body tumors, I found that it would be difficult because there had been only 49 cases in the literature up to 1949. I would, therefore, like to summarize the literature on this tumor; and, then, because Doctor Millen has indicated acquaintance with it, I will ask him for further comment.

There are two types. The one, very uncommon, usually a teratoma which occurs in children, usually females, gives precocious puberty. The other type, which we have here, has a microscopic picture which mimics the pineal body histologically. There are three groups of symptoms. One is caused by intracranial pressure. Second are the hypothalamic symptoms, which Doctor Millen has already listed for you. In general, they are those of diabetes insipidus, weight loss, the loss of hair, and the hypofunction of the endocrine system. The third group is more specific and is due to pressure on the corpora quadrigemina, causing the disturbance of pupils, nystagmus, diplopia, and faulty conjugation of eyes. In reviewing the case with Doctor Peters, who followed him for a long period of time, I asked whether it was possible to elicit, even in retrospect, the symptoms caused by the tumor of the corpora quadrigemina. He said that, due to the blindness of the patient, it was impossible to elicit any of the symptoms that I mentioned as belonging in this syndrome. So I think that it would be impossible to specifically make a diagnosis clinically of pineal gland tumor in this case.

**Doctor Millen:** I don't think we could have made this diagnosis absolutely preoperatively because, as was mentioned, there are three primary syndromes that tumors of the pineal gland produce. There are many who believe that the pineal gland doesn't actually have any active function in adults and that all the changes in such tumors are secondary to pressure of infiltration involvement of the hypothalamus. After all, the pineal gland itself is part of the epithalamus and part of the diencephalon, and all the parts of that whole structure are directly related one to the other. I can't conceive of a small tumor of the pineal gland, and I have not heard of any such tumor of the pineal glands small enough not to cause pressure on surrounding cell areas, yet producing very definite clinical syndromes. About the only symptom that might be an exception would be that of precocious puberty. The third syndrome is due to pressure upwards and backwards and then downwards against the quadrigeminal plate. Next to precocious puberty, paralysis of upward gaze is about the most characteristic clinical finding in pinealoma. Calcification in the pineal tumor is the clinching laboratory finding.

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# THE MEDICAL FORUM

## SMS PLACEMENT SERVICE FILLS COMMUNITY NEEDS

Dr. Stephen Cahana, Milwaukee, (center) receives certificate of public service from Dr. S. E. Gavin, Fond du Lac, (right) president of the State Board of Health, and silver plaque from Dr. H. Kent Tenney, Madison, immediate past president of the State Society.

### Doctor Cahana Retires After 28 Years On Board of Health

Madison, Oct. 30.—Dr. Stephen Cahana, Milwaukee, who in September announced his retirement from the State Board of Health after 28 years of service, was honored recently by Governor Walter J. Kohler, the members of the board of health, and the State Medical Society.

At a testimonial dinner in Madison, Dr. Cahana received a certificate of public service issued to him "in behalf of the people of Wisconsin who have lived in better health, enjoying fuller, longer lives as a consequence of his conscientious, constructive, devoted, Christian service." The certificate was signed by Governor Kohler and the seven other members of the board of health. Dr. S. E. Gavin, Fond du Lac, president of the board, made the presentation.

At the same time, Dr. H. Kent Tenney, Madison, immediate past president of the State Medical Society, presented Dr. Cahana with a silver plaque honoring him as "a

*(Continued on page 598)*

### Council Urges Support Of Rural Health Meet

Madison, Oct. 30.—The report of the SMS Council, adopted by the House of Delegates during the annual meeting in Milwaukee, called particular attention to the following activities:

1. The need for physician participation in the National AMA Rural Health Conference to be held in Milwaukee, Feb. 24–26, 1955.
2. Production and distribution of "The March of Medicine" on television for Wisconsin TV stations in late 1954.
3. The tape recording loan service of the medical society to the state's high schools as a "matter of prime concern."

The reference committee handling the Council report proposed that delegates and alternates sign registration slips at the time they are admitted to each session of the House, and their names then be checked against the list of authorized delegates and alternates. This will eliminate the issuance of credentials cards in advance of the sessions.

Madison, Oct. 30.—A total of 111 specialists and 100 general practitioners has applied to the State Medical Society's Physician Placement Service for advice in locating practices in Wisconsin, according to a report submitted to the House of Delegates at the annual meeting.

The House of Delegates was told that the society's Physician Placement Service has "more than tripled its activity during the past year in helping Wisconsin communities who are seeking physicians as well as assisting doctors interested in locating a new practice."

Of the 90 physicians who contacted the service since January, 15 were directly placed by the service in Wisconsin communities, 20 located in Wisconsin towns not listed by the service, and 55 located in other states, the report stated.

According to Dr. D. E. Dorchester, Sturgeon Bay, chairman of the Council on Medical Services, which directs physician placement activities, there were 211 known to be interested in locating in Wisconsin on October 1.

#### Includes Specialists, GP's

An even 100 of these were interested in general practice.

Sixteen of the physicians interested in general practice in Wisconsin said they would like to locate in towns having a population of 1,000 to 5,000. None specifically expressed an interest in smaller towns, although seven said they would like to practice in a "small community."

Eleven physicians were interested in towns of 5,000 to 10,000 population, another 11 wanted to practice in towns "over 10,000" and five were interested in towns above 20,000. Two said they weren't interested unless the town had a population of "100,000 or more."

Dr. Dorchester's report also revealed that many specialists are interested in locating in Wisconsin. The Placement Service, at the time of the report, listed the following

*(Continued on page 595)*

# Formulate New Program For Dependents' Medical Care

Washington, D. C., Oct. 15.—A uniform medical care program for military dependents is all set to go into operation when and if Congress passes the necessary legislation.

This is a report from the Washington Office of the American Medical Association concerning the preparation by the armed forces of a program for military dependents.

**Legislation to authorize the new program was introduced in the last session but was not acted on in either House or Senate. The plan calls for military hospitals and uniformed physicians to care for all dependents they are able to serve, with only the remainder to be treated by civilian facilities.**

The government would stand about 90 per cent of the costs, making direct payment to hospitals and physicians or underwriting hospital, medical care, and surgical insurance for those treated in civilian facilities. Dependents would be defined and the extent of care restricted.

The armed forces have already made extensive preparations to be ready to place the plan in operation. A tentative fee schedule has been set up modeled along the lines of the "well-known and generally-accepted Veterans Administration Guide for Medical Services."

A uniform "military dependent identification card" has been developed for use under the new program and is currently in limited use in the Navy and the Air Force.

The American Medical Association, while agreeing in general with other parts of the defense department plan, believes that the military medical department should care for civilian dependents only when civilian facilities are not adequate.

## Hill–Burton Construction Adds 14 New Hospitals

Madison, Oct. 15.—Fourteen hospitals, designed to provide an additional 500 beds, are now being built in Wisconsin under Hill–Burton hospital construction grants, according to the latest report from the Federal Security Administration's division of hospital facilities. The total cost of the building program is $9,824,065 of which the federal contribution is $3,884,605.

While no new projects have been approved in Wisconsin, construction already completed has added 1,457 beds to the state's facilities in the 32 hospitals now in operation. Total cost of these projects was $24,552,981. Hill–Burton funds supplied $8,764,087 of this amount.

Dr. George H. Fellman

## Milwaukee Doctor New Life Member

Madison, Oct. 25.—Dr. George H. Fellman, Milwaukee, became one of a select group of Wisconsin physicians recently when he was granted life membership in the State Society in recognition of his years of service to medicine in the state.

A member of the State Society's "50-Year Club" since 1948, Dr. Fellman recently completed his 50th year of continuous membership in both the Milwaukee County and the State Societies. He graduated from Rush Medical College, Chicago, in 1897. After interning at the Dependent Home for Children in Milwaukee, he began his practice as a pediatrician in that city.

Dr. Fellman has taught at Marquette University and has been on the attending staff of Milwaukee Hospital, Milwaukee Childrens Hospital, and the Milwaukee County Hospital. He has also been consulting pediatrician at the Johnson Emergency Hospital and the Deaconess Hospital in Milwaukee.

## *AMA Publishes Vet Care Bulletin*

Chicago, Sept. 13.—The first of a series of monthly newsletters about veterans' medical care was mailed recently by the American Medical Association to a selected list of state society committees concerned with this problem. The newsletter is published by the AMA Committee on Federal Medical Services in cooperation with the AMA Council on Medical Service.

Following its purpose of keeping the medical profession informed and up-to-date on current VA actions, the first newsletter covered new facts and developments in veterans' medical care.

## Propose New Features For Scientific Program At Annual Meeting

Madison, Sept. 15.—Dr. S. A. Morton, Milwaukee, and Dr. L. G. Kindschi, Monroe, have been given key roles in the preparation of the 1955 Annual Meeting program for the State Medical Society.

The assignments were given at a recent meeting of the Council on Scientific Work. Members of the Council, in addition to Drs. Morton and Kindschi, are Drs. J. W. Gale, Madison, chairman; P. A. Midelfart, Eau Claire; M. G. Rice, Stevens Point; R. S. Baldwin, Marshfield; J. S. Hirschboeck, Milwaukee, ex officio; and W. S. Middleton, Madison, ex officio.

Dr. Morton has suggested that the 1955 meeting of the State Medical Society, May 3–5, include a series of panel discussions rather than demonstrations as have been used in the past. The second day of the conference might be devoted to a series of special meetings which would be official scientific programs of recognized medical groups within the State Medical Society, such as the Wisconsin Surgical Society, Wisconsin Radiologic Society, and others.

Dr. Kindschi will assume the responsibility for developing the scientific exhibits for the 1955 meeting.

The Council has expressed hope that it will be possible to obtain a group from Michigan to present a special program on explosive accidents associated with anesthesia in the operating room.

# ANNOUNCE PROGRAM TO REPLACE DOCTOR DRAFT

Madison, Oct. 29.—Information has been received that the Defense Department and the Selective Service System have set up a new program to staff the medical services with physicians after the Doctor Draft Act expires next July 1.

**Under the plan, known formally as the Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program, all members of the 1954–55 intern class who have no previous military service and have been deferred from serving under the regular draft, have been sent forms in which they are to list their first, second, and third preferences of the services.**

Interns must, in addition, state whether they desire further deferment for residency training and their first and second choices of hospitals and specialization fields.

The Defense Department then turns the names over to the three services which send out applications for reserve commissions to be returned to the Pentagon Building in Washington by November 15.

**By December 15, the department will have drawn by lot the names of interns to be deferred for training in "specialties essential to the military medical services." Physicians not selected will be so notified.**

### On Inactive Status

Those who are deferred and who are taking their residency training in civilian hospitals will be on an inactive reserve status and will not receive pay or allowances from the service in which they hold reserve commissions. They will be eligible, however, to receive the regular stipend paid by hospitals. They will not be in uniform until called to duty on completion of their deferment.

The Department of Defense points out, however, that not more than one-fourth of all physicians believed eligible under the program can be given residency deferments.

Physicians selected for such deferments will serve their 2-year tour of duty when the military departments require their specialties.

### Need Approved Residency

**After completion of their internships in June, 1955, physicians not asking deferment will be able to indicate when they desire to enter service. The department said it would be necessary for physicians to arrange their residency in the institution of their choice. To be acceptable under the program, the residency must be fully approved by the AMA and by the American specialty board concerned.**

Comments the Defense Department: "There is no obligation to the armed forces for participation in this program other than the two years of active service which are required of registrants under the Universal Military Training and Service Act, which will be served on completion of deferment. Again, the number of residents under this program will depend upon the excess number of registrant physicians who are available to fill the requirements of the armed forces for physicians during any one year."

## Cite Milwaukee Society For Century of Service

Milwaukee, Oct. 22.—The Medical Society of Milwaukee County was one of four organizations honored at the annual dinner of the Milwaukee Association of Commerce for over 100 years of continuous service to the community. The dinner was held at the Schroeder Hotel in Milwaukee on October 21.

Dr. James G. Garland, Milwaukee, president of the Milwaukee society, responded to the association's tribute for the society and the other three groups honored The citations were given in recognition of the "contributions to the economic life of the community" of these groups.

The Milwaukee society was founded in 1846 and during its history has participated in a number of civic projects aimed at providing better health care. It was instrumental in clearing the swamps around the city, organizing a Board of Health, and securing ordinances for compulsory vaccinations. Today, in addition to its continuing public health activities, it provides a number of medical services including an emergency telephone service.

## NAME FUTURE "MEDIC" SUBJECTS

Madison, Oct. 29.—Those who have been following Dow Chemical Company's new TV program "Medic" over the NBC network on Monday nights will be interested in the titles and subjects to be covered in future broadcasts.

The recently released list includes the following:

November 22—"Day 10," bubonic plague; November 29—"My Very Good Friend Albert," hearing; December 6—"With This Ring," unwed mother; December 20—"Red Christmas," medical aspects of traffic accidents.


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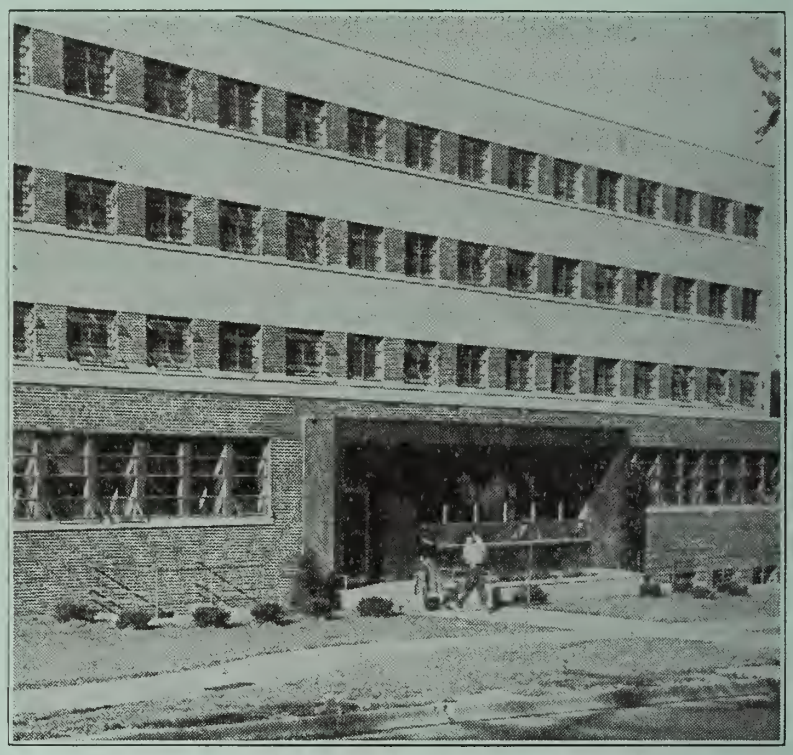
# DIAGNOSTIC CENTER FILLS PUBLIC HEALTH NEED

Madison, Oct. 25.—Ceremonies dedicating the unique Wisconsin Diagnostic Center in Madison September 10 and 11 provided another dramatic step in the life-long public health activities of Dr. William D. Stovall, Madison.

The first to see the need for such an institution in the state's mental health program, Dr. Stovall, a past president of the State Society, originally proposed the center and took an active part in its establishment.

Created for the study, diagnosis, and treatment of mental and emotional illness, particularly in children, the center handles patients referred by the State Department of Public Welfare. It also provides comprehensive clinical training for medical students and future psychiatrists at the University of Wisconsin.



Front view of recently dedicated Wisconsin Diagnostic Center.

### Second Unit Opened

The center is the second of two such units to be opened in the United States. It is the only one closly connected with a medical school.

Governor Walter J. Kohler and President E. B. Fred of the University of Wisconsin both paid tribute to Dr. Stovall when they spoke at the formal dedication of the center, the morning of September 10. Governor Kohler termed the center "A monument to the creative ingenuity of a leader among us and a tribute to the progress of Wisconsin people."

He cited Dr. Stovall's long public service and his present work as chairman of the board of the Department of Public Welfare saying: "Dr. Stovall has given his life to the betterment of public health in Wisconsin and, in large measure has been directly responsible for the leadership which has resulted in the expansion and improvement of Wisconsin's facilities for the care of the mentally ill."

President Fred declared that "the state will always be indebted to Dr. Stovall." Describing the cooperation between state agencies necessary to build and operate the center, he outlined the growth of the proposal and told how Dr. Stovall's idea had been carried to the legislature by the late Dr. George A. Hipke of Milwaukee and Senator Robert P. Robertson of Beloit. "Generations of students in medical, educational, and allied fields are certain to benefit from this great development," President Fred stated.

Members of the various University departments staff the center, providing specialized treatment in all major areas of diagnosis and rehabilitation, and making training in these areas available to students.

The center staff is under the direction of Dr. Leslie A. Osborn, who is also director of the Department of Public Welfare's Division of Mental Hygiene.

Major emphasis at the center is placed on early treatment of emotional disorders in children. A large portion of the building has been sectioned into children's wards and treatment rooms, one of which is a rumpus room. The building also contains facilities for adults, a basement cafeteria, conference rooms, offices, and nurses quarters.

### Heralds New Era

Speaking on a scientific program held in conjunction with the dedication exercises, Dr. Franklin Ebaugh, clinical professor of psychiatry at the University of Colorado, heralded the center as representing a "new era in psychiatry." Presiding at the scientific program was Dr. Hans H. Reese, professor of neuropsychiatry at Wisconsin.

One of the highlights of the dedication was Dr. Stovall's own statement of the role of the diagnostic center. He said: "People can understand physical disease. Their unwillingness in the past to accept psychic trauma in early life that produces pathological manifestations has retarded the proper care of many patients. Now that psychic trauma is accepted as a fact in the illness of human beings, this diagnostic center becomes tremendously important."

## *Dr. Hutter Heads Geriatrics Group*

Madison, Oct. 25.—Dr. A. M. Hutter, Fond du Lac, was named chairman of the Society's Division on Geriatrics of the Commission on State Departments during the annual meeting.

The Council made the appointment to fill the vacancy created by the resignation of Dr. J. A. Schindler, Monroe.

## PLACEMENT SERVICE . . .

*(Continued from page 591)*

specialists seeking locations in Wisconsin:

| | |
|---|---|
| Surgery | 33 |
| Internal Medicine | 25 |
| Obstetrics and Gynecology | 9 |
| Eye, Ear, Nose and Throat | 6 |
| Pediatrics | 6 |
| Urology | 6 |
| Radiology | 5 |
| Pathology | 2 |
| Anesthesiology | 2 |
| Dermatology | 2 |
| Industrial Medicine | 1 |
| Orthopedics | 1 |
| Psychiatry | 1 |
| No Information | 12 |

Several physicians specified that they would like to locate in Northwestern Wisconsin, the Appleton area, or in small rural practice.

At the same time, there were 57 communities seeking physicians, according to Dr. Dorchester.

Almost all of the 57 communities are under 1,000 in population. Many of them lost their last physician in recent years through death or moving to larger trading centers.

## Dr. Gundersen Heads Oral Surgery Study

Chicago, Oct. 15.—Dr. Gunnar Gundersen, La Crosse, past president of the State Society, and trustee of the American Medical Association, has been appointed chairman of a national committee to study problems relating to oral surgery. The appointment was made by the AMA board of trustees at a recent meeting in Chicago.

**Members of the committee are AMA president, Dr. Walter B. Martin, Dr. Leonard Larson, Bismarck, N. D., another trustee, and Drs. Paul W. Greeley, Chicago, and Lawrence R. Boies, Minneapolis.**

The committee was formed in response to a report acted upon by the AMA house of delegates at its meeting last June. The report, given by the Reference Committee on Medical Education and Hospitals, dealt with the definition and scope of oral surgery and recommended that the board appoint a committee "representing all interests involved" to study the problem.

## STRESS NEED FOR COOPERATION IN SCHOOL HEALTH CONFERENCE

Madison, Oct. 21.—More than 350 persons demonstrated the mounting interest in school health problems when they attended the Regional School Health Conference at Central State College in Stevens Point on October 20.

Dr. E. H. Pawsat

Far outstripping the two previous conferences, the attendance figures included physicians, dentists, school administrators and teachers, public personnel, parents, and students, according to Dr. E. H. Pawsat, Fond du Lac, chairman of the Division on School Health of the State Medical Society.

Keynote of the meeting, sponsored jointly by the State Society and the State School Health Council, was the need for increased cooperation and coordination of efforts of the groups influencing school health. Discussions of current health problems highlighted the program of the 1-day meeting.

Dr. E. S. Gordon, Madison, professor of medicine at the University of Wisconsin medical school, and Dr. H. Kent Tenney, Madison, immediate past president of the State Society, were featured speakers on the general program. Discussing "The Integrated Physical and Emotional Growth of Children," they pointed out that mental health is considered the nation's number one health problem today. They stressed the need for early treatment of emotional problems while the cause can still be corrected.

The afternoon sessions consisted of workshop panel discussions on such topics as health examinations; problems involved in such diseases as epilepsy, rheumatic fever, and tuberculosis; preventive mental health; and referral of children with emotional problems.

Physicians participating as members or leaders of these panels included the following: Drs. Henry Anderson, Stevens Point; L. J. Bayer, Merrill; John J. Suits and Arthur J. Macht, both of Marshfield; George Handy, Wisconsin Rapids; and Drs. Gordon, Pawsat, and Tenney. Dr. A. J. McCarey, Green Bay, president of the State Medical Society, extended the welcome for the State Society.

Commenting on the conference, Dr. Pawsat said: "These meetings have given the medical profession an opportunity of demonstrating positive leadership in good health practices in our public and parochial schools."

A fourth regional conference is being planned for Milwaukee in early February, 1955.

### Calling ALpine 6–3101 . . .

**As of midnight, November 20, 1954, the exchange name, Alpine, will be added to the State Medical Society's telephone number, 6–3101. To call the Society after November 20, both the exchange and the number must be used. The addition is of particular importance to long-distance callers since after November 20 all Madison numbers will have an exchange. It will be impossible to reach the Society through its old number. Call Alpine 6–3101.**

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# All Around The Town

## *Old Homes Now Business Places*
## *The Collins House*

[ By ALEXIUS BAAS ]

TO THE OLD TIME Madisonian who grew up in the comparatively sleepy town of the turn of the century the encroachments of business upon what used to be the finest residential sections of the city come as something of a shock. Dozens of old homes are yielding to the inexorable demands of business incidental to Madison's rapid growth.

Perhaps no better examples of this change can be found than a number of stately dwellings on East Gorham street. All Around The Town plans a series of feature articles briefly sketching the history of some of the city's residences that have undergone this transformation and in this the first group under consideration, turns to the street just named.

Alexius Baas

At 704 East Gorham st. on the northeast corner of the intersection of that with North Blount stands what was formerly the **William H. Collins home**, now the headquarters of the State Medical Society of Wisconsin.

This fine mansion was built by Mr. Collins who, with his wife, nee Dora Kinney, came from Michigan to Madison to make this city their home. The date of construction was 1914. Mr. Collins was a prosperous and well-known wholesale and retail lumber dealer with yards in 11 Wisconsin cities. The house was the last word in solid and beautiful residence construction of its day. The interior woodwork is of rich mahogany imported from South America. Several of the rooms of the first floor have ceilings cross timbered by this precious wood. The house itself is built of double brick deep red in color.

* * *

William H. Collins was a successful business man but his interest did not stop there. He was a member of the Madison Board of Education, influential in the Park and Pleasure Drive, and an ardent promoter of the Madison Vocational School.

Six children were born to William Collins and his wife—**William Jr., John C., Paul C., Dorothy** (Mrs. T. W. DeWitt), **Joseph S.,** and **Catherine E.** Of these the last two live in Madison. Catherine, from whom I received the above information, is a youth counselor at East Side High School and makes amateur theatricals her hobby.

William Collins died in 1923. His wife survived him until 1949. Possession of the house passed to a Johnson family and later to William McKay. It was converted into apartments. In 1948 the State Medical Society of Wisconsin acquired title and moved in in the autumn of that year.

* * *

This society has an interesting history. It was organized by the Territorial Legislature in 1841 and continued under legislative act by the first State Legislature in 1848. It has had uninterrupted existence ever since. The society is interested primarily in four things:

The exchange, through meetings, of scientific information which includes the progressive education of medical men after graduation from college and the maintenance of the Wisconsin Medical Journal;

Public Health Education (example, the weekly recorded broadcast by Dr. Robert C. Parkin, director of Graduate Medical Education—this being one of various activities with a prospect of television before long);

Medicine in relation to public health as exemplified by the regular examination of children;

Medical Economics—the advocating of voluntary insurance and kindred subjects.

* * *

The society at present employs 60 people. The first floor of the building is given over to administrative offices — the second floor houses the Wisconsin Medical Journal and the Veteran's Medical Service Agency—the third floor is occupied by the Blue Shield.

One of the society's most interesting activities is the compiling of a Medical History of Wisconsin which involves the collecting of old manuscripts, biographies, etc., and also the recording of the current data on every practicing physician in the state—such materials to be turned over to the State Historical Society.

**"This means that the history of medicine in Wisconsin is writing itself,"** says C. H. Crownhart, general manager and secretary, **"and one can visualize the cumulative results 50 years from now."**

Madison's society is one of 25 units scattered about the state. The first president of the Wisconsin State Medical Society was **Dr. Mason C. Darling** of Fond du Lac.

This article has been reproduced from the October 9, 1954 edition of *The Capital Times* of Madison.

The following Madison physicians have held that office:

**Dr. E. S. Carr, 1860; John Fayville, 1872; Gilbert E. Seaman, 1909; Charles Sheldon, 1914; C. R. Bardeen, 1920; C. A. Harper, 1931; Reginald Jackson, 1933; W. D. Stovall, 1948; and H. Kent Tenney, current president. Dr. F. L. Weston is treasurer and Dr. Nels Hill member of council.**

* * *

Said Earl Thayer, assistant secretary of the society and in charge of its public relations:

**"We have outgrown these quarters. We hope that by spring we will be occupying our new building on the south shore of Lake Monona where we will have work for 80 employes."**

"How about 10 years from now?" I asked.

"Our new home will be so designed, he replied, "that we can build on to it when we need more room."

## County Groups Invited To Sponsor Contests

Madison, Oct. 30.—The Association of American Physicians and Surgeons has invited county and state medical societies and their auxiliaries to become local sponsors in the association's 1955 national essay contest for high school students.

**"The Advantages of Private Medical Care" is the subject of this year's contest. A project of the association's Freedom Programs Inc., the contest is designed to educate high school students on the question of socialized medicine.**

Major cash awards will be made in the national contest. The association suggests that three or more cash prizes be awarded in the local contests.

Local contests should begin by January 1 so that the three top essays may be submitted in the national finals by April 1. A judging committee including a physician, an educator, and a person with special knowledge of the subject is recommended. Package libraries for research may be obtained free of charge from the association.

Inquiries concerning the contest may be addressed to: Dr. Mal Rumph, Chairman, AAPS Essay Contest Committee, Suite 318, 185 N. Wabash Ave., Chicago 1, Ill.

## TB Christmas Seals Emphasize Need For Continuing Fight

Madison, Oct. 30.—Although more than 3,000 tuberculosis victims were hospitalized in sanitariums in Wisconsin in 1953, only 217 people in the state died from the disease that year.

These figures, recently released, lend emphasis to the 1954 Christmas Seal campaign as a means of continuing the fight against TB.

Sponsored by the Wisconsin Anti-Tuberculosis Association, this year's Seal campaign will begin on November 22. It marks the fiftieth anniversary of the Christmas Seal.

The sharp decline in deaths from tuberculosis in recent years is due, in large measure, to the active program which has been carried on to inform the public and provide free examination facilities. Last year, 1,432 new cases of TB were reported in Wisconsin, a decline over the 1952 figure.

**Help Fight TB**

**Buy Christmas Seals**

Physicians have taken a leading part in this program. The State Medical Society's Division on Tuberculosis and Chest Diseases, acting under the Committee on State Departments, has cooperated with both voluntary and state agencies.

## Fall Golf Tournament Brings Tie Play-off

Madison, Oct. 15.—Dr. Charles W. Stoops, Madison, became the new champion of the Wisconsin State Medical Golf Association in a dramatic 19th hole play-off after he and Dr. Stanley E. Zawodny, Milwaukee, had tied with scores of 78 in the association's fall tournament.

**The tournament was held October 4 at the Ozaukee Country Club, Thiensville, in conjunction with the annual meeting in Milwaukee of the State Medical Society.**

Two other winners, Drs. Alvin T. Grundahl, West Bend, and Warren H. Williamson, Racine, also tied, for the lowest net scores. Each had a 70. Other winners in the tournament were the following: Longest drive, hole 1, Dr. William Buggy, Milwaukee; Longest drive, hole 11, Mr. Stephen Fuller, Milwaukee; Closest to pin, hole 9, Dr. Williamson; Closest to pin, hole 16, Dr. William T. Casper, Milwaukee.

**Dr. Stoops, (right) new champion of the Wisconsin State Medical Golf Association, receives his first place trophy from A. H. Luthmers, Milwaukee, of the Milwaukee County Medical Society, who is executive secretary of the golf association. Dr. Gordon J. Schulz, Union Grove, president of the association, watches. Presentation came after play-off decided championship at association's fall tournament during the annual meeting.**

## WHAT'S NEW In Medical Films

This column lists recently released motion pictures. Included are both professional scientific films and those suitable for various lay groups and allied professions. These films have not been reviewed by the State Medical Society but are listed as a service to program chairmen of county and local societies and other groups.

### Scientific

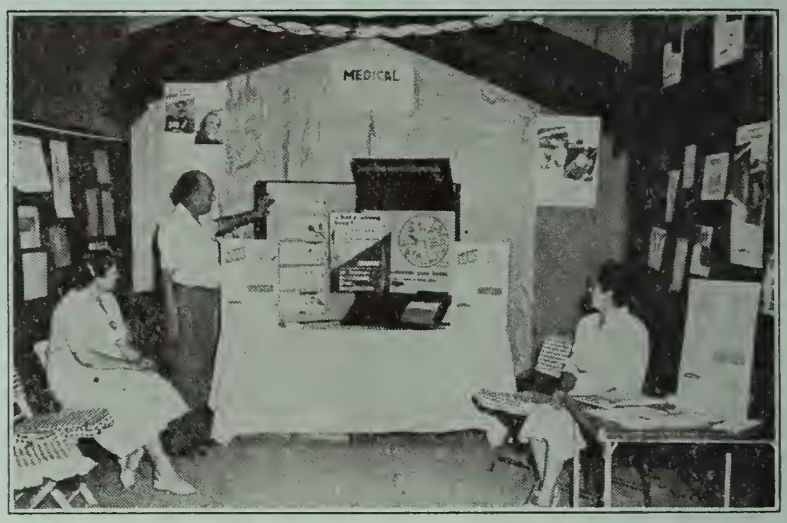
Lung Cancer: The Problem of Early Diagnosis: 16 mm., color, sound. Showing time, about 30 minutes. The most recent in the series of "early diagnosis" films of the American Cancer Society. Procurable on loan from Wisconsin Division, American Cancer Society, 652 E. Gorham st., Madison 3, Wis.

### General

America's Untapped Asset: 16 mm., black and white, sound. Showing time, 13 minutes. Sponsored by the President's Committee on the Employment of the Physically Handicapped, this film is a consideration of how and where physically handicapped people can fit into the business world. Of interest to both professional and business groups. Procurable on loan from the Committee on Medical Motion Pictures, American Medical Association, 535 N. Dearborn st., Chicago 10, Ill.

Cancer Quest: 16 mm., color, sound. Showing time, 28 minutes. A description of cancer research, filmed at McArdle Memorial Laboratory, University Hospitals, Madison. Designed for high school and adult groups, particularly guidance councilors. Procurable on loan from Wisconsin Division, American Cancer Society, 652 E. Gorham st., Madison 3, Wis.

Working for Better Public Health Through Recognition of Feelings: 16 mm., black and white, sound. Showing time, 25 minutes. A description of acceptable and unacceptable human relations situations for those engaged in public health work. Of particular interest to public health personnel. Procurable on loan from the Film Library, State Board of Health, State Office Building, Madison 2, Wis.




**Visitors to the Langlade County Fair, held in Antigo, found valuable health information in a special booth prepared by the Langlade County Medical Society Woman's Auxiliary. Here Mrs. C. E. Zellmer, left, president of the auxiliary, and Mrs. F. H. Garbisch watch as Dr. Zellmer checks the display on home accidents. All are of Antigo. The booth featured first aid displays, health tips, and information on Blue Cross–Blue Shield membership. A special poster advertised subscriptions to "Today's Health," a state-wide auxiliary project.**

## DOCTOR CAHANA . . .

*(Continued from page 591)*

true and devoted physician and a noble servant of public health."

Many congratulatory messages received at the time of the dinner, cited Dr. Cahana for his service to medicine and contributions to public health in Wisconsin.

Reverend Anthony F. Berens, S. J., regent of the Marquette University School of Medicine, hailed Dr. Cahana as a "horse and buggy doctor in the Atomic Age." He said Dr. Cahana "had long since discarded the horse and buggy in his scientific practice but has retained the horse and buggy doctor's love of his patients."

Reverend E. J. O'Donnell, S. J., president of Marquette University, cited Dr. Cahana's "outstanding work and the spirit of unselfishness and consideration of others which motivated it." Dr. Cahana is emeritus associate clinical professor of medicine at Marquette.

Born in Rumania in 1880, Dr. Cahana came to Milwaukee shortly after the turn of the century. In addition to his many professional activities, Dr. Cahana found time to put his knowledge of the French, Italian, and Rumanian languages to use, doing volunteer translating and interpreting for the International Institute of Milwaukee County. One of the letters he received upon his retirement was a message of appreciation from Sharon L. Hatch, executive secretary of the Institute, for his efforts in this work.

Attending the dinner honoring Dr. Cahana, in addition to the board of health members, the Governor, and Society representatives, were Dr. W. D. Stovall, Madison, director of the State Laboratory of Hygiene, and Dr. Walter Zeit, Milwaukee, of the department of anatomy at Marquette.

## RESOLUTION HONORS WISCONSIN NURSES

Madison, Oct. 25.—A request that the 13,771 nurses in Wisconsin be "paid high tribute during National Nurse Week, October 11–16, 1954" was adopted by resolution at the House of Delegates during the SMS annual meeting in Milwaukee.

At the same time the delegates recorded their "appreciation of the Woman's Auxiliary for its work in nurse recruitment, and supplying literature, personnel and scholarship funds."

The House also pointed out the critical need for all types of nursing personnel to assure adequate patient care in hospitals, specialized institutions, and the home. It offered the services and facilities of the State Medical Society for a joint effort to further improve nursing education and distribution in the state.

# Improved Method of Palpation of the Submaxillary Triangle

By KURT WIENER, M. D.
Milwaukee

RECENTLY I saw a patient who had had a wedge excision of a cancer of the lower lip. I found a smooth scar without local residue or recurrence. In examining the submaxillary regions, I palpated without difficulty a small, hard, movable node inside the right jaw, near the angle. The left side was normal. I referred the patient to a surgeon who does a great deal of oral work for block excision. The surgeon examined the patient but was unable to find the node and therefore did not wish to operate on the patient. The patient came back to me, I examined him again, and again there was the hard node. This time I marked the spot, called the surgeon, and explained the way I routinely examine the submaxillary trigonum. The surgeon followed the directions and called me saying that with the outlined technic he had immediately found the node which he had missed before.

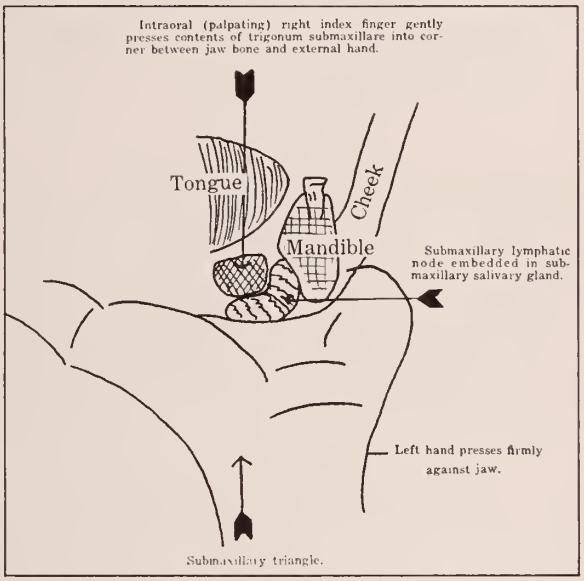



**Fig. 1—Palpation of submaxillary triangle.**

This incident made me think that the simple technic of palpation which I had applied may not be generally known and, because of the obvious importance of the submaxillary trigonum in the diagnosis and treatment of lip and oral cancers, might be worthwhile to discuss.

The success of examination by palpation depends mostly on the degree of resistance which the palpating finger receives. An immovable bone offers extreme resistance and can hardly be missed. A relatively hard mass like a metastatic node can be so movable that it is hardly palpable. It "floats" in the connective tissue and is pushed away by the palpating finger which finds no resistance. Thus, the node may be impalpable. A lymphatic node which is not adherent to the bone in the submaxillary triangle is an example. If palpated from the outside only, it may not offer any resistance and may be missed. Much better is a bimanual palpation with one index finger on the floor of the mouth under the tongue and inside the alveolar ridge, the other on the outside, medially from and below the jaw. With this method, the "floating" mass may be prevented from escaping by the intraoral finger, but it may still happen that the node is pushed aside and thus escapes. If, however, the external finger or, better, *the hand is firmly pressed against the jaw* and if then the intraoral palpating finger gently pushes the structures of the submaxillary region into the corner which is formed by the jaw and the external hand, escape is not possible. Suddenly one feels the remarkable improvement in the picture of palpation. Under normal conditions, the soft submaxillary salivary gland can be palpated, something often claimed to be impossible. Normal lymph nodes are hardly palpable. If they are enlarged and hard, they replace the much softer salivary gland in the perception. If they are large and adherent to the bone, they cannot, of course, be missed by any method of palpation.

425 East Wisconsin Avenue.

# THE WISCONSIN MEDICAL JOURNAL

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# « « « EDITORIAL » » »

## A Salute to Doctor Cahana

Our hat's off to Dr. Stephen Cahana of Milwaukee, a fine Christian physician well deserving of the recognition he has had from his patients, from his fellow men, and from his colleagues. Especially are plaudits due for his devoted public service as a member of the State Board of Health for nearly 28 years. His has been a steady, guiding hand, largely unheralded, as he discharged his responsibilities as a member of the board over the years.

Few can look back on their years of public service with as deep a sense of satisfaction over the progress in public health as can Doctor Cahana. Witnessing, as he has, the almost complete elimination of diphtheria, typhoid fever, smallpox, and scarlet fever as childhood killers; viewing the spectacular reduction in tuberculosis deaths and deaths of mothers in childbirth; observing the average age of death among his Wisconsin neighbors increasing from 50 years in 1927 to nearly 64 years in 1953, great indeed must be his gratification.

During Doctor Cahana's years of service, there have come about the addition of 17 divisions to the organization of the Board of Health; the establishment of the present district health units; the development of one of the largest and most active board of health visual aids libraries in the entire country; and, more recently, realization of the dream of a new State Laboratory of Hygiene building to better serve the people of the state.

In presenting Doctor Cahana with a certificate of public service at a recent testimonial dinner, the Governor and members of the Board of Health expressed merely a small token of the honor that is due him "in behalf of the people of Wisconsin who have lived in better health, enjoying fuller, longer lives as a consequence of his conscientious, constructive, devoted, Christian service."

Thus, it is with profound regret that we view the close of so distinguished a career of public service as has been Doctor Cahana's. A special salute from those of us in the medical profession, the public health field, and the general public, all of whom stand indebted to him for his unprecedented period of selfless devotion to the cause of better health in Wisconsin—C. N. Neupert, M.D.

*Facts about*

"THE DOCTORS PLAN

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

## Where Goes Blue Shield?*

Many years ago when the idea of voluntary medical insurance existed chiefly in the minds of a few doctors, there were some who feared that a Frankenstein might be in the making. That United Medical Service has developed to giant size, no one will question. That it may come to exercise an overbearing influence on the lives and practices of physicians deserves careful thought.

Members of the medical profession who sit on the governing board of UMS shoulder very serious responsibilities. If these medical spokesmen are alert and vocal, no vagrant trend of thought in the minds of the officers and administrative staff of UMS will be permitted to gain acceptance.

What is now Blue Shield was originally conceived by its early sponsors as a planned service for the public good. Whatever best serves the public must in the end prove to be best for the medical profession. There is a mutual concern in the proper growth of this community service.

The yearly payment of millions of dollars by Blue Shield to physicians, for the medical care of a large segment of our population, is a vast enterprise. Its importance in the economic lives of doctors is great and rapidly becoming greater. In this early period of growth this organization must be held strictly in hand. It should serve, not become master. The profession of medicine would be derelict if it permitted such a powerful influence to assume a ruling control in medical care.

Through the physician representatives in the great financial institution that is Blue Shield, the profession should make clear what are the real needs of the people and the doctors. It will then be up to the leadership of Blue Shield to find the "ways and means." Blue Shield cannot be allowed to dictate to the profession what it can have.

In a recent issue of the UMS Bulletin, Dr. Louis H. Bauer says, "No plan can be successful without the cooperation of the doctors who deliver the services." We endorse this idea and shall give full support to its implementation.

In the business of providing payments for medical care, doctors can profit by the advice of lawyers, insurance actuaries, and the experience of successful administrators of industrial institutions. But the interests and thoughts of doctors cannot be subordinated and disregarded, if there is to be the cooperation necessary to enduring success.

The preservation of the right of a patient to a "free choice of doctor" and reasonable payments for the services performed are sound principles. The progressive extension of UMS Blue Shield coverage to embrace the services of all doctors should be encouraged. In this we must not be impatient. It is being done with commendable skill and due caution.

*This is a reprint of an editorial which appeared in *New York Medicine*, Volume X, No. 16, August 1954. United Medical Service in New York corresponds to Wisconsin Physicians Service. Dr. Louis H. Bauer is Chairman of the Board of Directors of the United Medical Service and a past-president of the American Medical Association.

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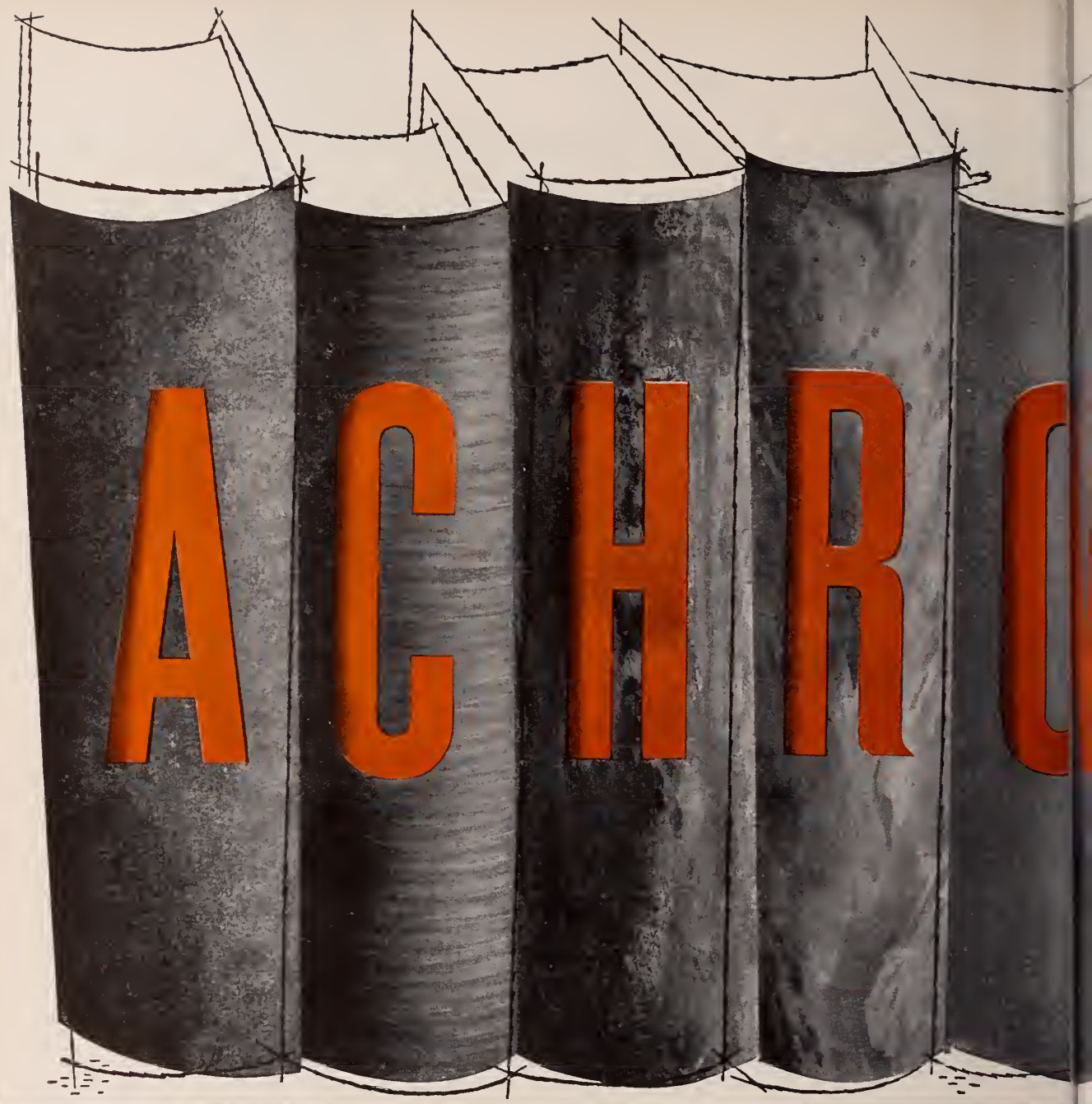


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# Making Statistics Reliable

## As It Looks to Your State Board of Health

*"Statistics: The systematic compilation of instances for the inference of general truths."*—WEBSTER

A PHYSICIAN from India recently visiting our state was greatly impressed by the wealth of statistical data available on maternal and child health in Wisconsin. This is not surprising, for we have almost complete records on births, deaths, and fetal deaths, and it is from this great mass of certificates filed by physicians that Wisconsin statistics are compiled. In recent years the availability of special sorting and tabulating equipment has made it possible to assemble more information than ever before.

Statistics, however, depend upon more than a mass of data and the equipment to tabulate it. Only when statistics present an accurate picture of factors as they exist can they be truly useful to the physicians, medical schools, hospitals, public health and other community agencies that are studying and working to meet local problems. It is well, therefore, to remind ourselves from time to time that data compiled can be only as reliable as the data submitted and to ask ourselves if we are doing as much as we can to improve the completeness and adequacy of information reported.

Of all statistics available, probably those on births are the most accurate. Here we are dealing with large numbers, some 88,000 a year; and an occasional inaccuracy in reporting, although not to be condoned, does not materially affect the statistics for the state as a whole. The greatest problem seems to be in recording weight and length of infants, particularly of the immature infants. There are also occasional contradictions. For instance, "spontaneous delivery" is checked and a reason for an operative delivery given. This may be due to more than one person supplying information; for example, a hospital nurse or intern filling in part of the certificate. It is important that wherever such practice occurs the physician read the certificate and correct necessary items before signing it.

When we come to death statistics, we are dealing with far smaller numbers; and every omission and error is therefore magnified. This is especially true when we begin to review deaths from any one cause.

The Maternal Mortality Study Committee in studying maternal deaths for 1952 found they were not always in agreement with the cause of death as reported. The most striking differences seemed to be on certificates carrying such vague statements as "shock," "pulmonary embolism," or "hemorrhage," although factors such as rupture of uterus, tears, or lacerations were indicated from case studies. Sequence of events also was not always clearly defined. In deaths due to toxemia, for example, it is important to know whether there was cardiac or renal disease previous to pregnancy. An autopsy should be obtained whenever possible and a corrected report filed if the clinical diagnosis differs from that previously reported.

Fetal-neonatal death studies conducted by local doctors and hospitals indicate that only a small proportion of fetal death certificates carrying combined birth and death data show weight and length of the infant. On these certificates, it is important to avoid "immaturity" or "premature birth" as a cause of death whenever possible. This is rarely the cause of death in infants weighing over two pounds at birth, although sometimes the cause may be the same as that responsible for the interruption of pregnancy.

Atelectasis (partial expansion or later collapse of the lungs) may be the cause of death in a liveborn infant. In a fetal death, however, where the lungs have never functioned, it should probably never be entered as the cause of death. In both instances, it is helpful if the underlying cause can be determined. When anoxia is entered, it becomes important to know whether an infarct of the placenta, a premature separation, cord complication, over-narcotization, or prolonged labor are responsible factors.

For some years the State Board of Health has been matching birth and death certifi-

cates before assigning cause of death since physicians often fail to include related birth data on the death certificate.

Over the years, statistics from births and deaths have been helpful in locating special problems and providing information on which to base postgraduate programs and research. It is hoped that statistics will become even more useful through the interest and responsibility Wisconsin physicians take in the careful reporting of pertinent information on vital records.

Some suggestions are:

Review entries of hospital or office personnel for accuracy.

Discuss entries with other physicians involved in the case.

Clarify sequence of events needed for coding purposes.

Obtain autopsies to verify diagnosis.

File corrected diagnosis should autopsy report warrant it.—AMY LOUISE HUNTER, *Director, Section on Maternal and Child Health.*

## WISCONSIN ACADEMY OF GENERAL PRACTICE SCIENTIFIC ASSEMBLY

The sixth annual scientific assembly of the Wisconsin Academy of General Practice will be held from November 29 through December 1 at the Milwaukee Auditorium. All Wisconsin physicians, whether members of the Academy or not, are invited to the meeting. There is no registration fee. The assembly will include two full days of scientific sessions; and Academy members who attend both days' sessions are allowed 12 hours of formal postgraduate credit.

Following is the program for the two days of scientific sessions:

**Tuesday, November 30** (All scientific sessions at Juneau Hall, Milwaukee Auditorium)

*Morning Moderator:* FRANCIS P. LARME, M. D., New Holstein

| | |
|---|---|
| 8:00– 9:15 a. m. | Registration |
| 9:15– 9:30 | Address of Welcome—C. G. Reznichek, M. D., Madison, President |
| 9:30–10:00 | "Intramuscular Trypsin in General Practice"—Irving Innerfield, M. D., New York, N. Y. |
| 10:00–11:00 | Recess to view exhibits |
| 11:00–11:30 | "Carcinoma of the Lungs"—O. T. Clagett, M. D., Mayo Clinic, Rochester, Minn. |
| 11:30–12:00 | "Therapeutic Uses of Radioactive Iodine"—Raymond Keating, M. D., Mayo Clinic |
| 12:00– 2:00 | Lunch |

*Afternoon Moderator:* C. F. BRODERICK, M. D., Wisconsin Dells

| | |
|---|---|
| 2:00– 2:30 p. m. | "Use and Abuse of Intravenous Anesthetic Agents" — O. Sidney Orth, M. D., Madison |
| 2:30– 3:00 | "Postmaturity: Obstetric and Pediatric Aspects"—Stewart H. Clifford, M. D., Boston, Mass. |
| 3:00– 4:00 | Recess to view exhibits |
| 4:00– 4:45 | "Disc Syndrome"—Peter B. Golden, M. D., Madison |
| 6:30 | Buffet Supper and Planned Entertainment—Blatz Auditorium |

**Wednesday, December 1**

*Morning Moderator:* W. C. FETHERSTON, M. D., Milwaukee

| | |
|---|---|
| 9:00– 9:30 a. m. | "Some of the Common Diseases of the Skin"—Theodore K. Lawless, M. D., Chicago, Ill. |
| 9:30–10:00 | "Acute Renal Insufficiency: Lower Nephron or Toxic Nephrosis"—Francis D. Murphy, M. D., Milwaukee |
| 10:00–11:00 | Recess to view exhibits |
| 11:00–11:30 | "Prematurity: Obstetric and Pediatric Aspects"—Stewart H. Clifford, M. D. |
| 11:30–12:00 | "Acute Meningitides"—Thomas V. Geppert, M. D., Madison |
| 12:00– 2:00 | Lunch |
| 2:00– 2:30 p. m. | "Afibrinogenemia in Obstetrics"—Jack A. Klieger, M. D., Milwaukee |
| 2:30– 3:00 | "Maternal Mortality in Wisconsin"—F. J. Hofmeister, M. D., Milwaukee |
| 3:00– 4:00 | Recess to view exhibits |
| 4:00– 4:30 | "Treatment of Both Bone Fractures of the Leg"—Carlo Scuderi, M. D., Chicago, Ill. |
| 4:30– 5:00 | "The Causes for Unsatisfactory Results Following Cholecystectomy" — Manuel Lichtenstein, M. D., Chicago, Ill. |
| 6:30 | Cocktails and Annual Banquet—Wisconsin Club |

# Progress Report on the Wisconsin Maternal Mortality Survey

By the Study Committee* of the Division on Maternal and Child Welfare of the Commission on State Departments

THE COMMITTEE which has been duly appointed and authorized through regular channels of the State Medical Society of Wisconsin is able to make a progress report on its continuing survey of maternal deaths in this state. Although this report deals specifically with those deaths which were the result of pure obstetric causes, the scope of the Study Committee's activities includes deaths from all causes where pregnancy was in any way associated with the death. In order to make this a comprehensive study, it was deemed advisable to include ectopic pregnancies, abortions (spontaneous or induced), accidental deaths where pregnancy was present, and all medical complications in which pregnancy was an associated factor.

Of the sixty-six (66) cases statistically classified as maternal deaths during a 12-month period, only thirty-nine (39) were determined to be the result of pure obstetric causes; and of these, twenty-six (26) received careful study with the thought that, if circumstances had been different, some of these deaths might possibly have been prevented. A number of deaths due to associated causes such as suicides, accidents, and the like need no discussion. However, those deaths due to nephritis, severe cardiac diseases, diabetes, gastric or duodenal ulcers, and other chronic debilitating diseases assume significance in that, in a majority of instances, pregnancy aggravated the coincidentally existing conditions. Among the 39 obstetric deaths, ectopic pregnancy and abortions were included. Thus, the maternal death rate from pure obstetric causes for this 12-month period of study was 0.43 per 1,000 live births.

Physicians in Wisconsin who are responsible for the care of the expectant mother can well be proud of the record which has achieved this low maternal death rate in Wisconsin. In recent years, the maternal death rate has dropped from 2.8 per 1,000 live births in 1940 to 0.43 per 1,000 live births in this 12-month study period. However, perhaps further improvement is possible; and, in any event, surveys such as this can help to point out some of the factors which might, by greater attention to certain procedures, be responsible not alone for further lowering of the maternal death rate but at least preservation of the rate now achieved.

In all of the 39 deaths which were considered to be due to obstetric causes, the data submitted to the Study Committee was obtained by interview. A physician designated by the chairman of the interviewing committee contacted the attending physician under whose care the death occurred and arranged for an interview wherein an attempt was made to obtain all pertinent data concerning the care of the patient during the prenatal, labor and delivery, and postnatal periods; and with the consent of the attending physician, all hospital care, consultation, and autopsy reports were obtained. The interviewers tried to obtain this data down to the finest detail; and in the majority of instances, the Study Committee felt that they had at their command a fairly accurate report of each case. It was impressed upon the Study Committee that a maternal death is a tragedy which has a profound effect upon any physician in any way involved and that the cooperation and helpfulness given by the attending physician in this study was in and of itself an honest and sincere effort to help himself and others of us to allow that degree of perfection which might further the purpose of this study.

Before proceeding with an analysis of the 39 deaths which were thought to be due to pure obstetric causes, perhaps it may be well to again emphasize that this is a *study* and not an investigation. The members of the Study Committee have a full realization of their responsibilities in this respect and believe that it is always easier to look backward rather than forward and much easier, in doing so, to possibly find the answer. Therefore, when the members of the Study Committee have arrived at a diagnosis other

* T. A. Leonard, M.D., Madison, Chairman; J. W. Harris, M.D., Madison; Alice D. Watts, M.D., Milwaukee; F. J. Hofmeister, M.D., Milwaukee; R. J. Sanderson, M.D., Beloit; E. D. Wilkinson, M.D., West Allis.

than that given by the attending physician, they have done so with the feeling that, if ideal conditions could have existed to within 100 per cent, exact diagnosis at the time might have been attained. We hope and dream for this ideal; we may perhaps never quite attain it, but we can come closer to our ultimate goal. The members of the Study Committee have attempted, in all humility and with a deep sense of responsibility, to resolve each case honestly, according to our abilities. With the above explanation of purpose and effort, we will proceed with the analysis of the 39 obstetric deaths.

Of the 26 deaths which might possibly have been prevented had circumstances been different, three were the result of non-cooperation of the patient; that is, the patient not having sought care until too late or not having abided by the physician's instructions.

The ages of the patients varied between 18 years and 45 years, with an average age of 31 years. Most deaths occurred within the mid-childbearing years.

### Autopsies

Of the 66 cases studied, only 18 were subjected to autopsy. Of the 26 cases in which unusually difficult circumstances existed, only two were autopsied.

The Study Committee felt that if an autopsy had been performed in the majority of these cases, it would not only have helped the Study Committee but also would have given the attending physician and the family a source of explanation as to the actual cause of death; and this would have been of great material benefit to all concerned.

### Multiparity, an Important Consideration

Of the 26 deaths mentioned above, 23 were in multiparas. Even though this is a small series, it again emphasizes that multiparity carries with it far more danger than primiparity. Numerous statistical studies verify this conclusion. The Study Committee wishes to emphasize that the multipara should be subjected to all the requirements which constitute good obstetric care and that we as physicians should avoid the false conception that the multipara, having once delivered one or more children, has a special protection conferred upon her.

The study revealed that statistics gathered from death certificates recorded at the State Board of Health were at variance with the conclusions arrived at by the Study Committee. Most maternal mortality surveys have revealed similar discrepancies and bring out the fact that data obtained from death certificates alone does not give an accurate picture of maternal mortality causes. It is believed by the Study Committee that these variances result from the fact that many times a supposed cause of death may not be the actual cause. In addition, many physicians are not aware of the fact that supplementary evidence which may change the original report of cause of death can and should be transmitted to the State Board of Health as a means of making final statistics more accurate. If more autopsies were obtained, there would be a higher degree of accuracy in reporting the causes of deaths on the death certificate.

### Hemorrhage

Hemorrhage was the most important cause of maternal death in this study and resulted from three major conditions: (1) ruptured uteri; (2) ectopic pregnancies; and (3) hypofibrinogenemia.

Ruptured Uteri: The Study Committee was impressed with its findings that there were 15 ruptured uteri in the 39 maternal death cases and felt that several phases of hemorrhage associated with this disaster should be emphasized.

Ruptured uteri occurred most often from two causes: (a) manual dilatation of the cervix and (b) administration of oxytocics, especially in the grand multipara. The Study Committee feels that manual dilatation is a hazardous procedure seldom indicated and usually results in severe manual lacerations rather than dilatation. The use of Pituitrin, Pitocin, Thytuitrin, etc. in the grand multipara likewise resulted in lower segment rupture. The study thus far has revealed that both of the above procedures, being hazardous as they are, should be avoided. It also indicated the need for early recognition of the laceration or rupture and that the patient be subjected to corrections by either adequate repair or by hysterectomy, if indicated, rather than dependence on oxytocics (postpartum), packs, intravenous fluids, etc. Early recognition and early correction are the answer to this serious complication as life saving measures. Blood, rather than plasma, plasma substitutes, glucose, and saline, should be administered in adequate quantities as soon as available.

Ectopic Pregnancies: Among 13 deaths due to miscellaneous causes were three ectopic pregnancies with rupture and intra-abdominal hemorrhage. Two of these patients failed to seek care until it was too late for intervention. Another patient, although in semi-shock, was not operated upon because her condition was thought to be too poor a surgical risk. The tragedy of the ectopic pregnancy is that it occurs early in pregnancy, usually prior to the time that a patient has sought prenatal care. Once the diagnosis is made, however, there is only one way in which to control the bleeding of a ruptured ectopic pregnancy and that is by surgery. Shock should be controlled simultaneously; and even in cases which appear moribund, at times a favorable outcome will be obtained.

Hypofibrinogenemia: There were four cases of hypofibrinogenemia. Two were associated with abruptio placentae and one with placenta praevia; one was in a highly sensitized Rh negative mother carrying a dead fetus for several weeks.

The deaths from this cause were sufficiently significant to warrant consideration and discussion. The uncontrollable hemorrhage which results from unclottable blood leaves the physician helpless to prevent demise. It appears to the Study Committee that early recognition of abruptio placentae and the earliest possible delivery by the easiest means is in order. The continuance of the abruptio status apparently augments the degree of hypofibrinogenemia; and if delivery cannot be effected early by any other means, Cesarean section should be performed, and if a non-contractile uterus is found, it should be removed. If gross continued bleeding occurs in placenta praevia, the same rule should be applied rather than giving large amounts of citrated blood. In the case of the Rh sensitized mother carrying a dead fetus, if the physician decides to continue conservative care until such time as labor occurs, then blood studies with respect to clotting mechanism should be carried out until the patient is safely delivered.

Fibrinogen is not universally available but, if obtainable, may be of some help.

### Toxemia

In the 39 deaths due to pure obstetric causes, eight were associated with toxemia—three were preeclamptic, three were eclamptic (one associated with anesthesia and one associated with cerebral hemorrhage), and two were postpartum eclamptic.

In its analysis of the toxemic deaths, the Study Committee was of the opinion that adequate prenatal care, with due concern paid to the signs of early toxemia, and earlier hospitalization, earlier control, and earlier interruption of pregnancy after viability of the fetus and when the patient is brought under optimum control by sedation and dehydration procedures were essential. The study also demonstrated the hazard of the postpartum period with respect to the convulsive status; and the Study Committee wishes to advocate the careful watching of patients during this period and adequate sedation of the patient who was preeclamptic or eclamptic prior to delivery. Longer periods of hospitalization postpartum are advocated.

### Cesarean Section

There were four deaths following Cesarean section—one as a result of toxemia and postoperative bleeding, one as a result of a preeclamptic toxemia and pulmonary embolism, one as a result of postpartum hemorrhage, and one as a result of infection.

### Anesthesia

Since there were three deaths due to caudal anesthesia in this series, the Study Committee felt that the role which this anesthesia plays in obstetric management should be seriously evaluated by all hospital staffs.

### Other Causes

There was one perforated uterus associated with a criminal abortion in which the patient died of sepsis.

There was one cardiovascular accident associated with postpartum eclampsia.

There was one amniotic fluid embolism proved by autopsy.

### Summary

The above discussion lists the 39 maternal deaths reviewed during a 12-month period, giving the significant causes responsible for these deaths. Hemorrhage leads the list, with toxemia second. The deaths from several miscellaneous causes are listed. The role of hypofibrinogenemia is significant in the hemorrhagic deaths as well as the role of manual dilatation, oxytocics and version and extraction in the production of ruptured uteri.

On the basis of this study, the following suggestions are made to help in the betterment of our Wisconsin obstetric situation:

1. *Obstetric hemorrhage:* The cause is to be sought for and corrected, if possible, as soon as it occurs by:

(a) IMMEDIATE repair of vaginal or cervical lacerations;
(b) IMMEDIATE repair of, or removal of, the ruptured uterus;
(c) Less dependence on uterine and vaginal packs to control bleeding without thorough search for the source or cause of bleeding;
(d) Adequate blood replacement. This should be done early; and blood, rather than plasma, plasma extenders, or aqueous solutions of glucose and saline, should be used. Plasma or plasma extenders should be used only while blood is being made available. *There is no real substitute for blood in the emergency under consideration.*

2. *Avoid manual dilatation* or any other attempt at delivery through an incompletely dilated cervix.

3. *Version and extraction,* when properly indicated, *should be performed only when types of anesthesia which can thoroughly relax the uterus are employed.* It is important to note that $N_2O_2$ plus $O_2$ and caudal or spinal anesthesia are, in the opinion of the Study Committee, entirely inadequate for this procedure.

4. *Proper application of drugs:* Pituitrin, Pitocin, Thytuitrin and like substances are to be used with *extreme caution*—and then only when properly indicated—and they should be given in minimal dosage. It is important to note that these substances are especially dangerous in the grand multipara.

These drugs must not be used in cases where obstruction to the process of labor is present.

5. *Ectopic pregnancy:* There is only one way to stop a bleeding ectopic pregnancy—*by surgical means.* Fluids, and especially blood, should be counterparts of the above procedure.

6. *Early recognition of abruptio placentae:* The prophylaxis of hypofibrinogenemia consists of recognizing the abruptio placentae and the tense, tender, nonrelaxing type of uterus and resorting to surgery *before the uncontrollable state arises.*

The use of fibrinogen may be of some help in this condition, but as of this date it is not universally available. Efforts are under way to have fibrinogen at key locations in the state for availability to all areas.

7. *Recognition and proper treatment of eclampsia:* Eclampsia should be detected in the preeclamptic phase, and the patient should be hospitalized at that time as a prophylactic measure. These therapeutic measures are indicated: (1) more intensive therapy through sedation and dehydration procedures; (2) more effort to stabilize the eclamptic patient prior to delivery by induction or section; and (3) closer follow-up and control of the postpartum eclamptic patient.

8. *Choice of anesthetic:* Careful study by hospital staffs is suggested as to the place of the caudal anesthetic approach to obstetric problems and as to proper measures of control when and if it is used.

9. *Selection of cases where termination of pregnancy is indicated:* It is known that patients with chronic hypertension, cardiovascular renal disease, and severe residual rheumatic heart disease are extremely poor obstetric risks; and careful study should be directed to such cases to determine when termination of pregnancy is indicated. Nothing is gained by carrying such a patient through to term, with knowledge that survival is of little likelihood. No one gains from such a medical decision.

In spite of the above precautions, there is a residue of patients who do not seek medical attention until the course of illness is irreversible or who, because of religious faith, will not cooperate with the physician. Little can be done in such situations except to impress upon many agencies the importance of proper prenatal care in the hope that "pressure" from other sources will bring the patient to the attention of the physician sufficiently early so that some of the problems mentioned above can be met effectively.

In gross summary, it should be stated that the study indicates several areas for improvement, but three major considerations should be stressed—the need for better prenatal care, more and better consultations, and more autopsies so we all can have a clearer understanding of the true causes of death.

The Study Committee feels that the survey has presented material for thoughtful study by every physician in Wisconsin. It is hoped that the findings will suggest avenues through which some of the "marginal deaths" can be saved and Wisconsin's fine record even further improved.

# Society Proceedings

## Brown–Kewaunee–Door

The regular business meeting of the Brown–Kewaunee–Door County Medical Society was held on October 14 at the Elks Club, Green Bay. Dinner was served at 7:00 p.m.

Delegates to the House of Delegates of the State Medical Society reported on the proceedings of the House at its October meeting. Congratulations were offered by members to *Dr. A. J. McCarey*, Green Bay, incoming president of the State Medical Society.

## Fond du Lac

The Fond du Lac County Medical Society met at the Elks Club, Fond du Lac, on September 23. The following new officers were elected:

President—*Dr. N. O. Becker*
Vice-President—*Dr. Josephine Pallin*
Secretary—*Dr. H. J. McLane*
Treasurer—*Dr. James C. McCullough*

All of the officers are from Fond du Lac.

Thirty-two members of the society attended this meeting.

## Manitowoc

*Dr. Edwin C. Albright* of Madison was the guest speaker at the dinner meeting of the Manitowoc County Medical Society on September 23 at the Hotel Manitowoc. Doctor Albright, who is assistant professor of the Department of Medicine at the University of Wisconsin, spoke on "Thyroid Disease."

## Racine

Mr. A. O. Gaarder, Madison, was the guest speaker at the monthly meeting of the Racine County Medical Society at the Colonial Club, Racine, September 18. Mr. Gaarder spoke on professional management in relation to the medical profession.

## Trempealeau–Jackson–Buffalo

Members of the Trempealeau–Jackson–Buffalo County Medical Society met on September 28 at the Hotel Freeman, Black River Falls. Physicians from the Marshfield Clinic, Marshfield, presented the program. Those participating were: *Drs. George E. Magnin, John J. Suits*, Ben R. Lawton, and *T. J. Rice*.

## Walworth

The Walworth County Medical Society held its regular meeting on September 9 at the Sterlingworth Hotel on Lauderdale Lake near Elkhorn. Ten members heard an address by *Dr. Paul La Bissoniere* of Milwaukee who spoke on "Surgically Correctible Cardiac Anomalies."

It was announced that tuberculin skin testing is to be included with routine immunizations by the doctors of Walworth County since the public health office will no longer handle this service.

The Study Club of the society met on September 9 to discuss "Afibrinogenemia and Pulmonary Hyaline Membrane."

At the October meeting of the society, held at the Arizona Inn, Delavan, October 14, Dr. Donalee Tabern, in charge of radioactive pharmaceuticals at an Oak Ridge, Tennessee, laboratory, addressed the members. Invitations were extended to the members of the public school system to attend this meeting.

## Winnebago

*Dr. Marc J. Musser* of the University of Wisconsin Medical School, Madison, was the guest speaker at a meeting of the Winnebago County Medical Society held October 7 at the Athearn Hotel, Oshkosh. His topic was "Psychosomatic Medicine in General Practice."

Delegates to the House of Delegates of the State Medical Society reported on actions taken at the October meeting.

## John Warton Harris Obstetrical Society

The John Warton Harris Obstetrical Society held its annual meeting at the Wisconsin General Hospital, Madison, on September 3 and 4. Officers elected for the year 1954–1955 are as follows:

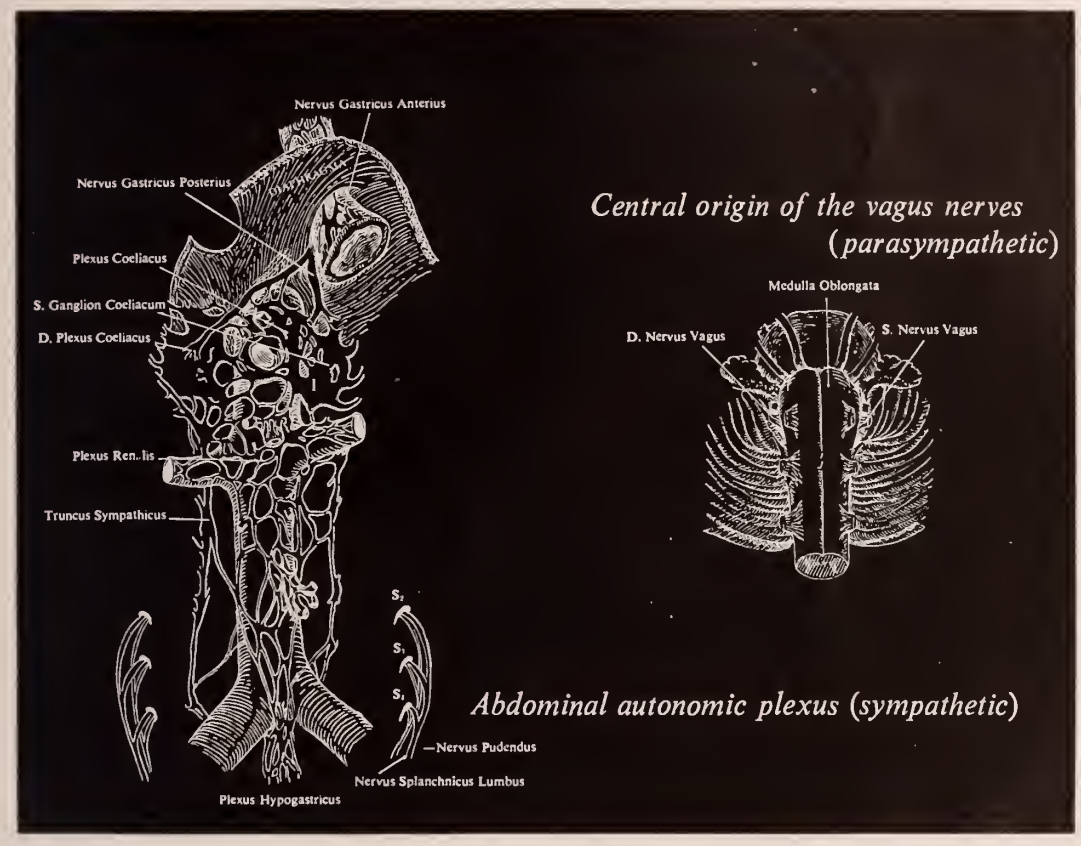
President—Dr. E. Russell Muntz, Ada, Oklahoma
President-Elect—Dr. William R. Knight, III, Houston, Texas
Secretary-Treasurer—*Dr. Alice D. Watts*, Milwaukee

## Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology

On September 11 and 12 members of the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met at Eagle Waters Resort, Eagle River, Wisconsin.

Speakers at the meeting included Dr. Maurice Snitman, Chicago, who spoke on "Anatomy of Head and Neck in Relation to Clinical Pathology" and "Clinical Features of the Head and Neck Pathology," and Mr. Robert Scott of Chicago who addressed the group on "Retinal and Anterior Segment Photography" and "Prosthesis Implants."

*Dr. G. L. McCormick* of Marshfield is secretary of the society.

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1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. *147*:1620 (Dec. 22) 1951.

# News Items and Personals

## Dr. Dell Andrus Honored

Ashland physician, *Dr. Dell Andrus*, was presented with a citation on September 15 for his meritorious service as aerie physician over many years in the Ashland aerie of the Eagles Club and as recognition for his many public services. The presentation was made at a special meeting in the Eagles Hall, Ashland.

## Doctor Evenson at Cedarburg

*Dr. Roland Evenson*, who recently completed his residency in eye, ear, nose, and throat at Marshfield, has associated with *Dr. Henry J. Katz* at Cedarburg. Doctor Evenson is a graduate of the Marquette University School of Medicine.

## Doctors Gehin and Erickson Open Office

*Dr. F. E. Gehin* and *Dr. J. R. Erickson* have established offices together in Stevens Point. Doctor Gehin specializes in internal medicine, while Doctor Erickson's specialty is surgery.

## Dr. J. K. Trumbo Resumes Wausau Practice

*Dr. James K. Trumbo*, who left Wausau in the fall of 1953 to take up residence in Augusta, Georgia, has now resumed his medical practice at Wausau. His specialty is eye, ear, nose, and throat.

## New Richmond Honors Dr. O. H. Epley

A community surprise party given on September 15 in honor of *Dr. O. Hoyt Epley*, New Richmond physician, marked his fiftieth year in the practice of medicine. The doctor and his wife were presented with two tickets to Europe, and the Pierce–St. Croix County Medical Society entertained the couple at dinner at The Terrace in Somerset, where Doctor Epley was presented with a purse and other gifts.

## Doctor Noble Returns to Black River Falls

*Dr. John Noble*, former staff member of the Krohn Clinic at Black River Falls, has returned to his position. He has been in military service.

## Doctor Phillips Re-establishes Practice in La Crosse

Following a year and a half in the Navy, *Dr. Paul W. Phillips* has returned to his practice with the La Crosse Clinic. He specializes in orthopedic surgery.

## Dr. James C. Fox in Postgraduate Work

*Dr. James C. Fox*, La Crosse, has taken a year's leave of absence from the La Crosse Clinic to complete his requirements for certification by the American Board of Internal Medicine. He will have a year of advance training at the Lahey Clinic, Boston, Massachusetts, returning about October 1, 1955.

## Staff Officers Elected at Manitowoc Hospital

At a recent meeting of the staff of the Holy Family Hospital, Manitowoc, *Dr. W. A. Rauch* was elected chief-of-staff for the ensuing year. Others elected were *Drs. C. J. Radl*, vice-president, and *George M. Simon*, secretary-treasurer. These officers, along with *Drs. N. C. Erdmann* and *H. J. Belson*, constitute the executive committee of the hospital.

## Dr. Robert Moore Discusses Diet

*Dr. Robert M. Moore*, Frederic, lead a discussion at a meeting of the Women's Auxiliary of the Frederic Municipal Hospital on September 24 at Friberg's Cafe. The discussion was on "Dieting to Reduce and General Health."

## Marathon County Society Co-sponsors Education Series

The Marathon County Medical Society is one of the co-sponsors of a family life education series being held weekly at Wausau. Others sponsoring this series of seven programs are the local University of Wisconsin Extension Center, the Marathon County Social Welfare Coordinating Council, the Wausau Ministerial Association, the Wausau PTA Council, and the Wausau Vocational School.

## Doctor McMahon Speaks on Highway Safety

At a meeting of the Toastmaster Club, Menomonie, on September 27, *Dr. A. E. McMahon* was one of the speakers. He discussed the problem of the growing accident rate on the highways in his talk entitled "Let's Get Tough."

## Dr. David Gallaher, Jr., Assisting in Wisconsin Rapids

*Dr. David M. Gallaher, Jr.*, who specializes in the practice of ophthalmology at Appleton, is also practicing one day a week at Wisconsin Rapids. The latter community has been without a full-time ophthalmologist for some time.

## Conference on Cardiovascular Disease at Green Bay

The second conference on cardiovascular disease, presented for professional nurses, was held at the Beaumont Hotel, Green Bay, October 20. Among the physician speakers were *Dr. S. D. Austin*, Green

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Bay, who discussed "Heart Disease and Pregnancy," and *Dr. A. B. Weinstein*, Madison, who spoke on "Congenital Heart Disease." The Brown–Kewaunee–Door County Medical Society was one of the co-sponsors of the conference.

### Doctor Beck Honored at Wautoma

*Dr. A. A. Beck*, Wautoma, was the guest of honor on September 19 on the final day of the Coloma Fall Festival. Doctor Beck marked the close of 45 years of service to the community.

### Bear Creek Physician Receives National Award

*Dr. L. F. Morneau*, Bear Creek, was presented the Joseph J. Trainer Rural Health Award at the National Catholic Rural Life Conference in Davenport, Iowa, on October 11. The award is presented annually for outstanding work with rural people in the field of medicine. Doctor Morneau is the first doctor to receive the citation.

## THIRD AND TWELFTH DISTRICTS NEWS

### Doctor Blum to Practice in Florida

*Dr. O. S. Blum* left Monroe in November to establish a practice in Florida. He has been associated with the Monroe Clinic in the specialty of ophthalmology and otolaryngology since 1950.

### Madison Physicians Speak at Dane Health Council

At an all-day annual meeting of the Dane County Association of Health Councils on October 14, the following Madison physicians participated in the program and discussion period: *Dr. Donald G. Dieter*, former chairman of the Diabetic Committee of the Dane County Medical Society, who spoke on "Diabetes"; *Dr. Horace K. Tenney, III*, attending physician at the Rheumatic Fever Convalescent Home, whose topic was on "Rheumatic Fever"; *Dr. John Shumate*, medical director of Lake View Sanatorium, who discussed "Tuberculosis"; and *Dr. George G. Stebbins*, chairman of the Subcommittee on Aging of the Community Welfare Council, who spoke on "The Aging."

### Doctor Coon President of TB Conference

*Dr. Harold M. Coon*, superintendent of the University Hospitals, Madison, was installed October 8 as president of the Mississippi Valley Tuberculosis Conference. The installation took place at the forty-first annual meeting of the conference at Kansas City, Kansas.

### Postgraduate Clinic at Madison

The twenty-fourth annual postgraduate clinic sponsored by Marquette University School of Medi-

cine was held at the Tower Room, Methodist Hospital, Madison, on September 25.

Speakers included *Dr. John S. Hirschboeck*, dean of the Marquette University School of Medicine, and *Dr. Christopher R. Dix*, Milwaukee, and, from Madison, *Drs. K. R. Petsch*, James J. Fowler, *Howard W. Mahaffey*, and *Arnold S. Jackson*.

Physicians in attendance and their wives were guests of the Jackson Clinic at lunch at the Hotel Loraine.

## Madison Doctor Attends Muscular Dystrophy Meet

*Dr. Henry A. Peters*, Madison, instructor of neuropsychiatry at the University of Wisconsin Medical School, attended the third conference of the Muscular Dystrophy Association of America on October 8 and 9. The conference was held in New York.

## Thirtieth Anniversary Celebration Held at Wisconsin General Hospital

On October 15, the State of Wisconsin General Hospital celebrated the thirtieth anniversary of its official opening. Award pins and buttons were presented to those who had been continuously employed since the opening date, as well as to those who had been continuously employed for 25 years.

A dinner which was held in the hospital cafeteria was attended by employees and staff of the hospital, as well as by the Regents and the President of the University of Wisconsin. During the after-dinner ceremonies, President E. B. Fred of the University of Wisconsin officially accepted a portrait of former governor Emanuel Phillip, painted by his son, Mr. Cyrus Phillip. Governor Phillip was governor of Wisconsin at the time that funds were made available for the building of the State of Wisconsin General Hospital.

## Doctor Meisekothen Joins Madison Physicians

*Dr. W. E. Meisekothen*, a graduate of the Stritch School of Medicine of Loyola University, Chicago, has joined the group practice of *Drs. C. G. Reznichek*, *R. J. Hennen*, and *E. E. Skroch*, Madison. The group is known as the East Madison Clinic.

## Doctor Crosley Appointed Department Director

*Dr. Archer P. Crosley, Jr.*, Madison, has been appointed director of the University of Wisconsin's Department of Preventive Medicine and Student Health. Doctor Crosley replaces *Dr. John W. Brown*, who was released from his duties for reasons of health. Doctor Brown will continue as professor of preventive medicine.

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## Dane

Members of the Dane County Medical Society and their guests participated in the annual golf tournament of the society held at Blackhawk Country Club on September 21.

On September 28, delegates of the county society to the House of Delegates of the State Society met in the library of McConnell Hall, Madison General Hospital, to discuss with the society's Board of Trustees matters to come before the House of Delegates at its October meeting.

The annual meeting of the county society was held at the Madison Club on October 12, with 80 members in attendance. Committee reports on the past year's activity were reviewed, and election of officers was held.

Officers for the new year are:

President—*Dr. George Hank*, Madison
President-Elect—*Dr. Robert S. Gearhart*, Madison
Vice-President—*Dr. E. J. Nordby*, Madison
Secretary-Treasurer—*Dr. Thomas V. Geppert*, Madison
Trustees—*Drs. M. S. Kellogg*, Oregon, and *W. T. Russell*, Sun Prairie
Delegates—*Drs. Charles Stoops, George Hank*, and *T. W. Tormey, Jr.*, all of Madison
Alternate Delegates—*Drs. Robert Becker, R. J. Hennen*, and *Russell Sinaiko*, all of Madison.

## Sauk

Twenty members of the Sauk County Medical Society heard a talk by *Dr. Charles W. Crumpton*, assistant professor of medicine at the University of Wisconsin, on October 12. The meeting was held at the Warren Hotel, Baraboo. Doctor Crumpton's topic was "The Treatment of Hypertension."

*Dr. John F. Moon* of Baraboo, delegate to the House of Delegates of the State Medical Society, reported on actions taken by the House at its meeting in October.

## Dr. Maurice Hardgrove Legion Medical Advisor

*Dr. Maurice Hardgrove*, Milwaukee, has been reappointed by Wisconsin Commander Martineau of the American Legion to be the Wisconsin Department Medical Advisor.

## Doctor Shaiken Speaks at Convention

*Dr. Joseph Shaiken* of Milwaukee addressed the national convention of the American College of Gastroenterology in Washington, D. C., on October 26. His subject was "The Female Patient with Duodenal Ulcer."

## Cardiovascular Disease Clinic at Marquette

On October 27, a Cardiovascular Disease Clinic was held at Marquette University School of Medicine Auditorium. Speakers were Dr. George Burch, professor of medicine, Tulane University, New Orleans, and Dr. Gilbert Blount, assistant professor of medicine, University of Colorado, Denver.

## Doctor Peterman Lectures in Holland

*Dr. M. G. Peterman*, Milwaukee, delivered a lecture at the University of Amsterdam in Holland on September 15. "Convulsive Disorders of Childhood" was his lecture topic.

## Milwaukee Academy of General Practice

Dr. Philip Thorek of Chicago addressed the members of the Milwaukee Academy of General Practice at their dinner meeting on September 29 at the Milwaukee Athletic Club. His subject was "Jaundice."

On October 19, the Academy met at the University Club, Milwaukee, to hear Dr. Austin M. Brues, director of the Division of Biological and Medical Research of the Argonne National Laboratory, speak on "Radiation Sickness."

## Milwaukee Neuro-Psychiatric Society

A meeting of the Milwaukee Neuro-Psychiatric Society was held at the University Club, Milwaukee, on October 4. The speaker was Dr. Leo H. Bartemeier, associate professor of psychiatry, Wayne University, Detroit, Michigan, and member of the National Advisory Mental Health Council. Doctor Bartemeier spoke on "Failures in Psychotherapy."

Officers of the society are:

President—*F. J. Millen, M.D.*, Milwaukee
Vice-President—*John Petersik, M. D.*, Winnebago
Councilors—*Owen C. Clark, M.D.*, and *Benjamin A. Ruskin, M.D.*, both of Milwaukee
Secretary-Treasurer—*Isaac J. Sarfatty, M.D.*, Milwaukee.

## SOCIETY RECORDS

### New Members

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W. J. Hanley,** 716 North 11th Street, Milwaukee.

G. F. Mueller, 710 North Plankinton Avenue, Milwaukee.

Betty Jane Bamforth, 1300 University Avenue, Madison.

### Changes of Address

R. G. Evenson, Marshfield, to Cedarburg.

T. J. Beno, Camp Chaffee, Arkansas, to 420 West Washington Street, Muncie, Indiana.

F. J. Davis,* Madison, to 1634 Moreno Street, Oceanside, California.

H. M. Bachhuber,* Sparta, to Camp Crowder Neosho, Missouri.

T. E. Kilkenny, New Orleans, Louisiana, to State Hospital for Crippled Children, Elizabethtown, Pennsylvania.

R. A. Starr, Astoria, Oregon, to 318 South Main Street, Viroqua.

J. D. Kabler, Wichita, Kansas, to 702 South Thornton Avenue, Madison.

L. W. Keller, A.P.O., Seattle, Washington, to 401 North Locust Street, Reedsburg.

A. E. Cowle, Great Lakes, Illinois, to 2 West Gorham Street, Madison.

D. H. White, Indianapolis, Indiana, to Apartment 4, 15 Sherman Terrace, Madison.

A. L. Rhoades, Madison, to Foss Clinic, Danville, Pennsylvania.

P. W. Phillips, Portsmouth, Virginia, to 212 South 11th Street, La Crosse.

John Huston, Jr, Milwaukee, to 1605 Chadbourn Avenue, Madison.

J. A. Palese, Chicago, Illinois, to 4815 South Lake Drive, Cudahy.

M. S. Tverberg, Camp Crowder, Missouri, to Mauston.

B. M. Zimmermann,* Milwaukee, to 221 Rue Max, Warrington, Florida.

W. E. Clasen, Milwaukee, to 5747 Monticello Avenue, Dallas 7, Texas

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## DEATHS

**Dr. Hjorleifur T. Kristjanson,** 78, Milwaukee surgeon and hospital staff physician, died September 19 at a Milwaukee hospital.

Born in Thingeyarsysla, Iceland, in 1876, he moved to Gardar, North Dakota, as a child. He received his medical degree from Rush Medical College, Chicago, in 1907 and interned at the Worcester, Massachusetts, City Hospital. He was also pathological intern at Rhode Island Hospital, Providence, for a year. For the next three years, he served as assistant superintendent and resident physician at the Providence, Rhode Island, City Hos-

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pital and also served as pathologist and bacteriologist at that institution. In 1912–13 he became assistant professor of bacteriology and pathology at the Medical School and State Public Health Laboratory at the University of North Dakota.

In 1913, Doctor Kristjanson joined the staff of Milwaukee County Hospital, serving as pathologist and resident roentgenologist until 1920 and as resident surgeon from 1915 to 1920. During the next five years he was part-time surgical pathologist at Milwaukee Hospital and on its staff. Later, due to an emergency, he also took charge of the Laboratory at the Milwaukee County Hospital again, serving part time for over two years. He was formerly a member of the visiting staff of St. Joseph's Hospital and Columbia Hospital and was assistant professor of clinical surgery at the Marquette University School of Medicine.

Doctor Kristjanson conducted a private surgical practice in Milwaukee for many years and made an extensive study of surgical conditions, with special attention to appendiceal infections and the management of cancer patients.

He was the holder of the first certificate issued by the National Board of Medical Examiners and served for two years as president of the Associated Diplomates of the National Board. He was secretary of the Milwaukee–Madison Subsidiary Board of the National Board for many years.

He was a Fellow of the American College of Surgeons, a member of the Milwaukee Academy of Medicine, the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

In 1944, Doctor Kristjanson became a member of the staff of the Veterans Hospital, Wood, Wisconsin; and he remained on the staff for several years. In 1948 he became a staff member at the Milwaukee County Hospital (Chronic) and remained there until his death.

He is survived by his widow, Marion; two daughters, Mrs. Marion A. Johnson, Buenos Aires, Argentina, and Mrs. Barbara H. Gustafson, Wauwatosa; a brother, Sigurdar, and a sister, Miss Kristin Kristjanson, both of El Cerrito, California.

**Dr. Lemuel D. Smith**, Milwaukee orthopedic surgeon, died on October 7 at the age of 71 years.

Doctor Smith graduated from the Marquette University School of Medicine in 1921. In World War I he was a lieutenant colonel in the Army's 135th medical regiment.

He was a former president of the Milwaukee Society of Clinical Surgery and the Alumni Association of the Massachusetts Institute of Technology.


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He was elected to the International College of Surgeons in 1940 and was honored by it for his research in bone and joint surgery.

Doctor Smith practiced in Milwaukee since 1925. He is survived by a son, James, Racine.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

JAMES C. SARGENT

Dr. James C. Sargent, widely known Milwaukee urologist and leader in state and national medical affairs, passed away suddenly on October 7 at Detroit, Michigan, at the age of 62 years.

Doctor Sargent, who was born at Piqua, Ohio, on October 3, 1892, was graduated from the Ohio State University College of Medicine in 1915. He completed a year of internship at Minneapolis City Hospital and six months at Children's Hospital, Columbus, Ohio, and then took a year of postgraduate work at the Brady Urologic Institute of Johns Hopkins Hospital, Baltimore, Maryland.

In 1917, he began his practice in urology in Milwaukee, where he had practiced until the time of his death, with the exception of a period of military service.

Doctor Sargent was president of the State Medical Society of Wisconsin in 1938 and had also served as delegate from the State Society to the House of Delegates of the American Medical Association. He was a past-president of the Medical Society of Milwaukee County and had served on its Board of Directors and several of its committees.

He was also a past-president of the North Central Section of the American Urological Association, a member of the Executive Committee of that association, and chairman of the Council on National Emergency Medical Service of the American Medical Association. He was a Fellow of the American College of Surgeons, a member of the American Urological Association and of the American Association of Genito-Urinary Surgeons. He was a Diplomate of the American Board of Urology.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Sargent entered naval service on March 1, 1942, as a commander. In 1945 he was promoted to the rank of captain; he received his discharge in November 1945. He had been located at the U. S. Naval Training Station in San Diego, California, from March 1942 to October 1943 and at the U. S. Naval Hospital, Shoemaker, California, from Octo-

ber 1943 to July 1945; he served as executive to the senior medical officer at Lido Beach, Long Island, New York, from July 1945 to October 1945.

He was clinical professor and director of the Department of Urology at Marquette University School of Medicine; a member of the Health Resources Advisory Committee to the Office of Defense Mobilization; a member of the National Advisory Committee to the Selective Service System; and senior consultant and director of the Department of Urology, U. S. Veterans Hospital, Wood, Wisconsin.

Doctor Sargent had also contributed to the literature in his specialty.

He is survived by his widow, Genevieve; his son, Dr. James W. Sargent; two daughters, Mrs. Mary Miller, Pewaukee, and Mrs. Suzanne Warnock, Indio, California; and a brother, Leroy D. Sargent, Washington, D. C.

**Dr. Edward P. Andrews**, Portage, died at his home on October 7 at the age of 80 years.

Born on May 9, 1874, he graduated from Rush Medical College, Chicago, in 1899 and opened his medical practice that year in Portage, with the late Dr. Byron Meacher. He moved to Lodi in 1908 but returned to Portage in 1913 and practiced there until his death.

He is survived by his widow, Isabelle, and a niece, Mrs. George Forester, LaGrange, Illinois.

**Jean M. Cooke**, retired Darlington physician, died September 26 at the age of 83 years.

Born on September 23, 1871, Doctor Cooke received her medical training at the University of Michigan Medical School, graduating in 1895. She then served for a year as prison doctor in the Women's Prison, Boston, Massachusetts.

Doctor Cooke then practiced medicine with Dr. Susanne Orton at Jane Addams Hull House in Chicago, where she remained for several years. In 1908 these two physicians established their medical practice in Darlington; here Doctor Cooke specialized in diseases of eye, ear, nose, and throat. In recent years she had retired from active practice.

There are no immediate survivors.

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Cat given the same amount of Distrycin has normal reflex.

On dosage of 1 Gm. per day for 120 days, ototoxicity was as follows*:

| | *Vestibular damage % of patients* | | |
|---|---|---|---|
| | *Mild* | *Moderate* | *Total* |
| Streptomycin | 12 | 6 | 18 |
| Dihydrostreptomycin | 6 | 0 | 6 |
| Distrycin | 0 | 0 | 0 |
| | *Cochlear damage % of patients* | | |
| | *Mild* | *Moderate* | *Total* |
| Streptomycin | 0 | 0 | 0 |
| Dihydrostreptomycin | 12 | 3 | 15 |
| Distrycin | 0 | 0 | 0 |

**Heck, W.E.; Lynch, W.J., and Graves, H.L.: Acta oto-laryng. 43:416, 1953.*

Distrycin dosage is the same as for streptomycin. In tuberculosis the routine dose is 1 Gm. twice weekly, in conjunction with daily para-aminosalicylic acid or Nydrazid (isoniazid). In the more serious forms of tuberculosis, Distrycin may be given daily, at least until the infection has been brought under control.

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*Distrycin is supplied in 1 and 5 Gm. vials, expressed as base*

# RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses by examination by the State Board of Medical Examiners at a meeting in Milwaukee, July 13 to 15, 1954.

| *Name* | *School of Graduation* | *Year* | *Address* |
|---|---|---|---|
| Acheson, William E. | University of Wisconsin | 1953 | Liberty St., Valders |
| Algiers, James Leonard | Marquette University | 1953 | 110 N. Main St., Hartford |
| Allain, James John | St. Louis University | 1953 | 6442 W. Birch, Milwaukee |
| Arkins, Robert Eli | University of Wisconsin | 1953 | Harper Hospital, Detroit, Mich. |
| Arndt, George William | University of Wisconsin | 1953 | 301 Troy St., Madison |
| Askotzky, Melvin M. | Marquette University | 1953 | 721 N. 17th St., Milwaukee |
| Barnett, Sheldon M. | Marquette University | 1953 | 1985 Seymour Ave., Cincinnati, Ohio |
| Beattie, Bernard W. | Marquette University | 1953 | St. Luke's Hospital, Milwaukee |
| Bines, Milton Michael | Marquette University | 1953 | 1719 W. Wright, Milwaukee |
| Borge, Alf Fosmark | University of Wisconsin | 1952 | Cambridge |
| Brady, James E., Jr. | Marquette University | 1953 | 6502 W. Birch Ave., Milwaukee |
| Bragman, Robert D. | Chicago Medical School | 1952 | 156 Rodney Ct., Madison |
| Carpenter, Frederick J. | University of Wisconsin | 1953 | 4835 W. Capitol Dr., Milwaukee |
| Carroll, Michael E. | Loyola University | 1953 | Milwaukee County General Hospital, Milwaukee |
| Claude, John Laurence | Marquette University | 1953 | 114 Wisconsin Ave., Oconomowoc |
| Cohen, Nathan Alan | University of Wisconsin | 1953 | 908 N. 12th St., Milwaukee |
| Coryell, John Lewis | University of Wisconsin | 1953 | 946 Spaight St., Madison |
| Coy, Douglas Joseph | Marquette University | 1953 | 7844 Harwood Ave., Wauwatosa |
| Crowley, William James | Marquette University | 1953 | 2108 N. 70th St., Wauwatosa |
| Cutting, Harry Martin | Marquette University | 1953 | 2723 W. Lincoln, Milwaukee |
| DeGroat, Frank L., Jr. | Marquette University | 1953 | 7400 W. Center St., Milwaukee |
| DeGroot, Henry E. | Marquette University | 1953 | 822 Hayes Ave., Racine |
| DeMarais, Lloyd C. | University of Wisconsin | 1952 | University Hospitals, Madison |
| Denio, Martin J., Jr. | Marquette University | 1953 | 523 Robertson, Wauwatosa |
| Domann, William A. | George Washington Univ. | 1953 | 133 N. Fond du Lac, Menomonee Falls |
| Franke, Glenn Henry | Northwestern University | 1953 | 3321 N. Maryland Ave., Milwaukee |
| Franklin, Burton Myer | University of Wisconsin | 1953 | VA Hospital, Wood |
| Geigler, James Edw. | Marquette University | 1953 | 6212 W. Greenfield, West Allis |
| Gerend, Thomas Joseph | Marquette University | 1953 | 216 Catherine, Kaukauna |
| Glassner, David M. | University of Wisconsin | 1953 | 2321 E. Glendale, Milwaukee |
| Goetsch, Frederick H. | University of Wisconsin | 1953 | Spooner Clinic, Spooner |
| Goldman, Margaret T. | University of Wisconsin | 1950 | 161 W. Wisconsin Ave., Milwaukee |
| Hackert, John Leonard | Loyola University | 1953 | Milwaukee County Hospital, Milwaukee |
| Hall, Mary Annette | Marquette University | 1953 | 4042 N. Wilson Dr., Milwaukee |
| Harkavy, Raymond | University of Wisconsin | 1953 | 3861 N. 53rd St., Milwaukee |
| Hatleberg, James L. | Marquette University | 1953 | 417 W. Willow St., Chippewa Falls |
| Hawkins, David Ramon | Marquette University | 1953 | 211 Hillside Ave., Queensville, N.Y. |
| Homsey, James Joseph | Marquette University | 1953 | 721 N. 17th St., Milwaukee |
| Horning, John Samuel | Chicago Medical School | 1953 | 8700 W. Wisconsin Ave., Milwaukee |
| Hunter, Richard Edmond | University of Wisconsin | 1953 | Argyle |
| Ivanov, Christine Jan | Marquette University | 1953 | 3308 N. Downer, Milwaukee |
| Jobling, Raymond Steven | Marquette University | 1953 | 8700 W. Wisconsin Ave., Milwaukee |
| Jochimsen, Earl Harvey | University of Wisconsin | 1953 | Mendota State Hospital, Madison |
| Kahn, Leonard | University of Wisconsin | 1953 | VA Center, Wood |
| Kass, Robert Martin | St. Louis University | 1953 | 8700 W. Wisconsin Ave., Milwaukee |
| Keiser, Orris Sterling | College of Med. Evangelists | 1953 | 37 W. Main St., Waupun |
| King, Jay Tenbrook | University of Kansas | 1953 | Merlham Dr., Madison |
| Kirby, Edward J., Jr. | Marquette University | 1953 | 826 E. Henry Clay, Whitefish Bay |
| Kjentvet, Roger Allen | University of Wisconsin | 1953 | Wild Rose |
| Knudsen, Else Marie | University of Denmark, Copenhagen, Denmark | 1940 | Iola |
| Koepke, Donald Edwin | University of Wisconsin | 1953 | University Hospitals, Madison |
| Laufenburg, Herbert F. | University of Wisconsin | 1953 | 563 N. Lake Drive, Whitefish Bay |
| Lipshutz, Sheldon N. | University of Wisconsin | 1953 | 4123 N. Ardmore, Milwaukee |
| Lyne, Benjamin W. | University of Wisconsin | 1953 | Neillsville Clinic, Neillsville |
| Lynch, John Denis | Marquette University | 1949 | University Hospital, Ann Arbor, Mich. |
| Maasch, Lloyd Palmer | Marquette University | 1953 | Box 175, Weyauwega |
| MacEwen, Almon Ray | Dalhousie University, Halifax, N. S., Canada | 1950 | Lutheran Hospital, La Crosse |
| Madden, Robert Francis | Marquette University | 1953 | 2931A N. 38th St., Milwaukee |
| Manago, Joseph Andrew | Loyola University | 1953 | 8700 W. Wisconsin Ave., Milwaukee |
| Mateicka, William Emil | Marquette University | 1953 | St. Joseph's Hospital, Milwaukee |
| McGaughey, Harry S., Jr. | University of Wisconsin | 1946 | University of Virginia, Charlottesville, Va. |
| McGrath, David James | University of Wisconsin | 1953 | 2262 W. Lawn Ave., Madison |
| McKenna, James Lewis | Marquette University | 1953 | 8700 W. Wisconsin Ave., Milwaukee |
| McMahon, John Martin | University of Iowa | 1953 | 1204 Wilson Ave., Menomonie |
| Meaney, James Joseph | Marquette University | 1953 | 818 N. 15th, Milwaukee |
| Motzel, Albert Joseph | St. Louis University | 1953 | 8700 W. Wisconsin Ave., Milwaukee |
| Mroczkowski, Chester J. | Marquette University | 1953 | 3241 S. 12th St., Milwaukee |

| *Name* | *School of Graduation* | *Year* | *Address* |
|---|---|---|---|
| O'Brien, Edward James | Marquette University | 1953 | 2045 N. 34th St., Milwaukee |
| Olson, Robert Charles | Marquette University | 1953 | 605 Minahan Building, Green Bay |
| Owen, Russell Henry | University of Wisconsin | 1953 | 921 16th Ave., Monroe |
| Peters, Earl Elmer | College of Med. Evangelists | 1953 | 37 W. Main St., Waupun |
| Philipp, Louis Daniel | University of Wisconsin | 1953 | 103 N. Pock St., Merrill |
| Pribek, Robert Andrew | Marquette University | 1953 | VA Hospital, Wood |
| Puls, Thomas Brian | Marquette University | 1953 | 2500 W. Lincoln, Milwaukee |
| Reed, Henry Hofmann | Kansas University | 1953 | 425 Lorch St., Madison |
| Riordan, John Francis | Marquette University | 1953 | 230 W. Madison St., Milwaukee |
| Rosenkranz, Wilbur E. | University of Wisconsin | 1953 | 1836 South Ave., La Crosse |
| Sadler, Paul Eugene | University of Oklahoma | 1952 | 2930 Barlow St., Madison |
| Sanders, John Ira | University of Wisconsin | 1952 | 2200 W. Kilbourn Ave., Milwaukee |
| Schaefer, Donald Leo | Marquette University | 1953 | 3109 W. Highland Blvd., Milwaukee |
| Schulz, Norman Henry | University of Wisconsin | 1953 | Mendota State Hospital, Madison |
| Seidl, Joseph Alois | Marquette University | 1953 | 323 South Central Ave., Richland Center |
| Seropian, Diran Menas | University College of Medicine, New York, N.Y. | 1949 | 425 Lorch St., Madison |
| Shamburek, Roland H. | University of Wisconsin | 1953 | 1910 9th St., Monroe |
| Skemp, Joseph Jerome | Marquette University | 1953 | 312 State St., La Crosse |
| Smith, Donald A. | University of Wisconsin | 1953 | Box 80, Albany |
| Smollen, William James | University of Wisconsin | 1953 | 1511 3rd Ave., N.E., Rochester, Minn. |
| Sorensen, Richard F. | Marquette University | 1953 | 7507 W. Center St., Milwaukee |
| Spankus, Jack Dean | Marquette University | 1953 | 3448 N. Downer Ave., Milwaukee |
| Spector, Jack Alan | University of Wisconsin | 1953 | 4229 N. 44 Place, Milwaukee |
| Sproule, Ralph Trostel | Northwestern University | 1950 | 208 E. Wisconsin Ave., Milwaukee |
| Sternlieb, Richard Owen | University of Wisconsin | 1953 | 3335 N. 44th St., Milwaukee |
| Stoerker, Ruth Arlene | University of Michigan | 1953 | 5–B University Houses, Madison |
| Stoll, William Morgan | Marquette University | 1953 | Mayo Clinic. Rochester, Minn. |
| Strassburger, Richard H. | St. Louis University | 1953 | 8700 W. Wisconsin Ave., Milwaukee |
| Stuesser, Glen John | University of Wisconsin | 1953 | Madison General Hospital, Madison |
| Theiler, George J., Jr. | University of Wisconsin | 1953 | 8700 W. Wisconsin Ave., Milwaukee |
| Theisen, Richard Bruce | University of Wisconsin | 1953 | Mendota State Hospital, Madison |
| Thomas, Thomas L. | Marquette University | 1953 | 2123 S. Layton Blvd., Milwaukee |
| Thompson, Thos. N., Jr. | Harvard University | 1953 | Neillsville Clinic, Neillsville |
| Thomson, Neil Reuss | Marquette University | 1953 | 721 N. 17th St., Milwaukee |
| Tibbitts, James Arthur | University of Wisconsin | 1953 | 114 S. Park St., Reedsburg |
| Trettel, Raymond James | Loyola University | 1953 | 8700 W. Wisconsin Ave., Milwaukee |
| Trettin, Robert James | Marquette University | 1952 | 2540 N. 45th St., Milwaukee |
| Turgeson, John Hays | University of Wisconsin | 1953 | 209 S. Charter St., Madison |
| Tuura, James Lynn | University of Wisconsin | 1953 | 1300 University Ave., Madison |

The following physicians were granted licenses by reciprocity by the State Board of Medical Examiners at a meeting in Milwaukee, July 13 to 15, 1954

| *Name* | *School of Graduation* | *Year* | *Address* |
|---|---|---|---|
| Asta, Joseph James | University of Minnesota | 1948 | 824 Medical Arts Building, Duluth, Minn. |
| Berlow, Stanley | Harvard Medical School | 1950 | 1513 E. Capitol Dr., Milwaukee |
| Bonnell, Ellis | University of Illinois | 1934 | 1220 Dewey Dr., Milwaukee |
| Britt, Archie George | University of Wisconsin | 1946 | 1508 Wood St., La Crosse |
| Davis, Vernam Terrell | Washington University | 1936 | 2001 Van Hise Ave., Madison |
| DeLeo, Nicholas Carl | Marquette University | 1952 | 2523 W. Glendale Ave., Milwaukee |
| Foster, James Joseph | Georgetown University | 1947 | 16 South Henry St., Madison |
| Gregg, Robert Henry | University of Iowa | 1947 | Howarden, Ia. |
| Greene, John Patterson | Duke University | 1950 | 814 El Prado St., W. Palm Beach, Fla. |
| Hellmuth, George A. | Loyola University | 1933 | 8700 W. Wisconsin Ave., Milwaukee |
| Hogan, Clifford William | University of Minnesota | 1940 | Box 165, Jamestown, N. D. |
| Kory, Ross Conklin | College of Physicians and Surgeons, Columbia Univ. | 1942 | VA Hospital, Wood |
| Lesesne, John Mitchell | Duke University | 1950 | 425 E. Wisconsin Ave., Milwaukee |
| Marshall, Bruce Rodger | Western Reserve University | 1947 | 2101 Latham St., Rockford, Ill. |
| Martins, James Kristian | University of Illinois | 1944 | Box 173, Eleva |
| Meyers, Chester Lionel | Chicago Medical School | 1951 | 3248 Edmund Blvd., Minneapolis, Minn. |
| Nesbitt, Tom Edward | Southwestern University Medical College | 1948 | 208 E. Wisconsin Ave., Milwaukee |
| Oliver, Cap Hill, Jr. | University of Texas | 1951 | 124 Washington Ave., Wisconsin Dells |
| Rattan, Walter Cooper | Harvard Medical School | 1948 | 6104 Third Ave., Kenosha |
| Rifleman, Robert Henry | Marquette University | 1952 | Box 7, Center, Colo. |
| Rose, Harold DeFrehn | George Washington Univ. | 1948 | Forbes A.F.B., Topeka, Kan. |
| Sonneland, John Edward | Northwestern University | 1948 | % R. J. Henderson, Tomahawk |
| Southcott, Walter C. | University of Wisconsin | 1950 | Columbia Hospital, Milwaukee |
| Stoops, William Arthur | University of Michigan | 1912 | Liberty Powder Defense Corp., Baraboo |
| Torkelson, Leonard Beck | University of Minnesota | 1952 | Baldwin Clinic, Baldwin |
| Trachtenberg. Lee Hershl | University of Illinois | 1952 | 181 E. Fairmont, Milwaukee |
| Von Ruden, William John | University of Illinois | 1952 | 139½ S. Main. Shawano |
| Woo, Theresa Ting | University of Michigan | 1934 | 20 Plattsburg Ct., Washington, D. C. |
| Zucker, Kenneth Lew | Northwestern University | 1949 | Box 2614, VA Hospital, Hines, Ill. |

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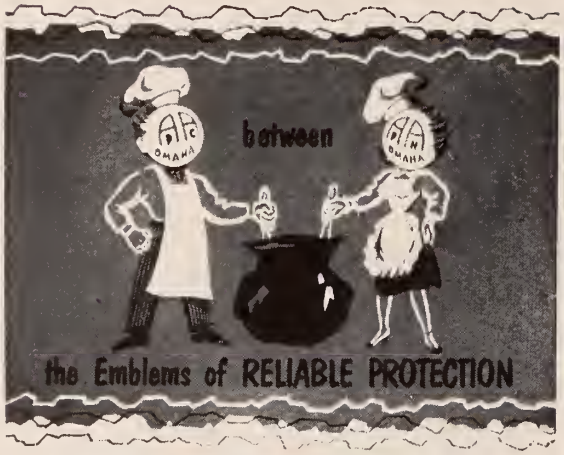


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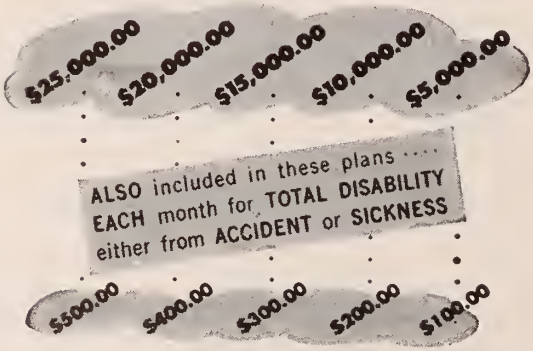


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THE WISCONSIN MEDICAL JOURNAL

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Volume 53 DECEMBER 1954 Number 12

# Cardiac Enlargement of Uncertain Etiology

By VINCENT W. KOCH, M. D., and DONALD E. KOEPKE, M. D.
Janesville Madison *

CARDIAC enlargement is a common manifestation of heart disease. According to White,[1] the cause is strain, whether intrinsic or extrinsic. The textbooks give long lists of the various causes for the condition, but not all cases of cardiac enlargement can be so catalogued. In spite of the most exhaustive diagnostic studies in some patients, no cause for the hypertrophy can be found. The term idiopathic hypertrophy has been applied to these cases. In 1901 Josseraud and Gallivardin[2] described the first of such cases. Since then, 30 more have been reported. We wish to add another one.

The patient, a 47-year-old man, was first seen in July 1950 because of severe dyspnea, chest and abdominal pain, and swelling of the lower extremities and abdomen. He occasionally had a slight fever.

He said he had not been well since May 1944, when he contracted malaria in Guadalcanal. Thereafter he continued to have episodes of weakness, aches, pains (especially in the joints), and fever. In 1946 he was a patient in a veterans' hospital, where a diagnosis of rheumatoid arthritis was made and chest x-rays and electrocardiograms were reported as normal.

In December 1946 he was hospitalized for pneumonia. He was then found to have enlargement of the heart, left pleural effusion (Fig. 1), and an abscess in the upper right quadrant of the abdomen; thick yellow pus was obtained from this abscess. Enlargement of the spleen and liver and a grade II apical systolic murmur were noted at that time. Fluid was aspirated from the chest and from the abdominal abscess on several occasions thereafter.

At the time of our first examination in July 1950, the patient's temperature was 102 F.; his pulse, 120 and grossly irregular; and his blood pressure, 140/90. He was well developed and well nourished but appeared chronically ill. Slight edema of the lower extremities and moist rales over both lower lung fields were noted. The heart was enlarged. The precordial area retracted with systole, and the left chest posterolaterally retracted with inspiration. The patient had a coarse pleuropericardial friction rub and a harsh grade III systolic murmur at the apex and below the scapula. His liver was 4 cm. below the right costal margin, and the abdomen was tender in this area.

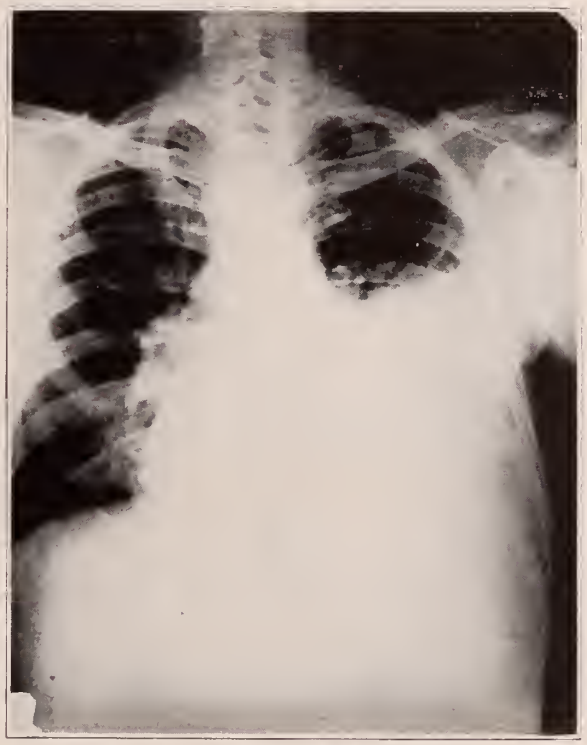

Fig. 1—X-rays showed a left-sided pleural effusion which obscured the left cardiac border. The cardiac silhouette appeared markedly enlarged. A lateral view indicated encroachment of the retrocardiac space.

The blood count and the urinalysis findings were normal, with the exception of the

*Doctor Koepke was a University of Wisconsin medical student, on preceptorship at Janesville, when this paper was written.

Fig. 2—The chest film showed marked cardiomegaly with enlargement of all chambers, mild chronic passive congestion, and right pleural effusion. On fluoroscopy, the heart pulsations were reduced, and changing the body position failed to produce change of heart position.

Fig. 3—There is progressive enlargement of the cardiac silhouette as compared to its size on films of July 1950. The lung fields show chronic passive congestion and pleural effusion at the base of the right lung.

finding of a mild albuminuria. Auricular fibrillation, left bundle branch block, right ventricular strain, and digitalis effect were interpreted from the electrocardiogram. Symmetrical enlargement of the heart, congestion of the lungs, and right pleural effusion were seen on the chest x-ray (Fig. 2).

The diagnosis was nonconstrictive pericarditis. The man was treated with digitalis, ammonium chloride, low-sodium diet, Mercuhydrin, belladonna tincture, and vitamins.

In August 1951 he went into a severe congestive failure. His hemoglobin was 66 per cent; the red blood cell count, 3,400,000; and nonprotein nitrogen, 55. Abdominal paracentesis yielded 19.1 liters of thin straw-colored fluid with specific gravity of 1.018. No organisms were grown from it. The patient gradually improved; but in October 1952 he was again hospitalized, semiconscious, with severe congestive heart failure. The cardiac enlargement had progressed (Fig. 3). He responded slowly to treatment thereafter; and, except for occasional short periods of partial restoration of cardiac competence, he went steadily downhill and died December 16, 1952.

## Necropsy

The body was 68½ inches in length and weighed 145 pounds. The abdomen was above the level of the chest and was marked by the scars of several paracentesis wounds. The lower half of the body was edematous, and the legs had irregular ulcers.

The abdominal cavity contained a large amount of fluid. Many dense adhesions involved the liver, diaphragm, stomach, spleen, and transverse colon. Near the anterior edge of the right lobe of the liver in the falciform ligament was a thin walled cyst, 8 cm. in diameter, filled with clear amber fluid.

The pleural cavities were obliterated by dense fibrous adhesions.

The heart weighed 700 Gm. and, except for enlargement of the chambers and thickening of the walls, was grossly normal throughout. The valve leaflets were unchanged. The intima of the coronary vessels had a few fatty plaques. A soft, easily detached thrombus, 3 by 2 cm., was found at the apex of the left ventricle. The lungs were normal. The spleen was enlarged.

### Microscopic Examination

The muscle fibers of the heart were hypertrophied. In places there was an increase in eosin staining, relatively acellular, fibrous connective tissue between muscle bundles; and in scattered areas it replaced muscle fibers. Slight diffuse infiltration with lymphocytes, larger mononuclear cells, plasma cells, and Anitschkow's myocytes was seen. Fibrous connective tissue was accumulated beneath the endocardium of one section. The collagenous fibers were parallel to the surface. The subepicardial fat was atrophied. The intima of one of the coronary arteries was thickened excentrically by pale, eosin staining, partially necrotic material containing small cleftlike spaces and macrophages with foamy cytoplasm.

The liver showed evidence of severe, prolonged, chronic, passive congestion and chronic perihepatitis. The capsule was thickened by dense, fibrous connective tissue with parallel collagenous bundles. The connective tissue external to the capsule was somewhat looser in texture. The fibrosing process extended into the liver parenchyma in places between liver lobules.

The wall of the right upper quadrant cyst was composed of dense, relatively acellular, fibrous connective tissue with slight diffuse and focal infiltration with lymphocytes. No epithelial cells were seen in the lining. In places there were lobules of fat undergoing serous atrophy. A few of the kidney glomeruli were hyalinized.

The anatomic diagnosis was idiopathic cardiac hypertrophy; mural thrombi, left auricular appendage and left ventricle; myocardial and subendocardial fibrosis; mild coronary sclerosis; obliteration of both pleural cavities by fibrous adhesions; peritoneal adhesions, with pseudocyst in right upper quadrant; chronic perihepatitis; chronic perisplenitis; ulceration of pelvic peritoneum; ascites; chronic passive congestion of the lungs, liver, spleen and kidneys; and severe stasis dermatitis.

### Discussion

Our patient gave a history of seven and one-half years of progressive cardiac failure, with collections of large amounts of fluid in the abdomen and lower extremities. The cause was not determined; and nothing in the history, physical examination, or necropsy findings offered an explanation for the cardiomegaly and eventual fatal outcome.

Rheumatic fever and hypertension could not be established as etiological factors. Kaplin, Clark, and de la Chapelle[3] offer evidence to support the theory that some cases of cardiac enlargement of undetermined origin are the result of marked antecedent hypertension. However, in this case, the complete records from the veterans' administration hospital where this man was a patient prior to the onset of his cardiac condition exclude hypertension.

No evidence of chronic pericarditis was found at autopsy.

We believe the evidence excluded postinfectious and syphilitic myocarditis, beriberi, myxedema heart, and von Gierke's disease. Pneumonia was not an etiological factor, nor was amyloid disease.

Thirty cases similar to ours have been reported. Only 3 were females; 27 were males. The average age was 38 years; the oldest was 66, and the youngest was 11 years of age. The average heart weight in this series was 580 Gm.; normal is 300 Gm. The largest reported heart weighed 1,150 Gm. The average duration of illness from the onset of symptoms was 18 months. Our patient had the longest duration of cardiac symptomatology, seven and one-half years.

Reifenstein and Chidsey[4] reported an eleven-year-old boy who suddenly rose from his seat in school, cried out loud, fell to the floor, and died within a matter of minutes. Microscopic examination revealed hypertrophy of the cardiac muscle, with increase of the fibrous tissue between the muscle bundles. The weight of the heart was 430 Gm.

Dyspnea was the presenting complaint in 16 patients, abdominal pain and swelling in four, precordial pain in four, palpitation in three, and ankle edema in two. Most of the patients had transient low-grade fever. A family history of heart disease was elicited in only four instances. The cardiac arrhythmias were variable; bundle branch block and auricular fibrillation occurred most frequently. The arrhythmia frequently changed from one type to another. Six of the patients had normal sinus rhythm. Paroxysmal tachycardia, premature contractions, ventricular and auricular flutter, A-V nodal rhythm, and

the various degrees of heart block were among the other arrhythmias reported.

At autopsy, dilation of the chambers of the heart, with hypertrophy of the muscular wall, was observed in all of the patients. The muscle bundles were hypertrophied. In 43 per cent of the patients, the fibrous tissue in the myocardium was increased; and 36 per cent had degeneration of the cardiac muscle fibers. The endocardium appeared thickened in 21 per cent of the cases; vacuolization was seen in 16 per cent, but special stains did not indicate the presence of glycogen. Slight round cell infiltration into the myocardium was present in 13 per cent of the patients, while focal necrosis and areas of small hemorrhages were noted in 10 per cent. Antemortem thrombi were common; they appeared in 33 per cent of the cases.

The cardiac muscle fiber degeneration, focal areas of necrosis, and the areas of fibrosis between the myocardial bundles may be explained on a deficiency basis. As the heart enlarges, it outgrows its blood supply, with decreased oxygenation and nutrition to the myocardium, which accounts for the pathological changes observed microscopically. Experimentally, similar lesions have been produced in rats fed diets deficient in potassium,[5] but this work has not been applied to humans. Subendocardial fibrosis is commonly associated with congestive heart failure. With continued failure of the chambers to empty completely, circulatory stasis, with poor oxygenation and nutrition of the endocardium ensues. The result is degeneration; necrosis; and, eventually, fibrosis of the endocardium. Ante-mortem mural thrombi formation is explained on the basis of this circulatory stasis.

The basic pathogenesis of the enlargement and hypertrophy remains unexplained. Whether there are single or multiple causes is not known; and, until the underlying factors are demonstrated, therapy can only be supportive, with the main reliance on digitalization, mercurial diuretics, and low-sodium diet.

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(V. W. K.) Munn-Koch Clinic.

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*(A complete list of references will be given on the author's reprints)*

## THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The eighteenth annual meeting of The New Orleans Graduate Medical Assembly will be held March 7 to 10, with headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include fifty-four informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, medical motion pictures, scientific exhibits, round-table luncheons, and technical exhibits.

The Assembly has planned another interesting postclinical tour to follow the 1955 meeting in New Orleans. On Saturday, March 12, a party composed of doctors and their families will leave New York for Europe via Pan American World Airways' "President Special." The itinerary includes France, Italy, Germany, Denmark, Sweden, and England; and arrangements have been made for medical programs in these countries. The tour ends in England, and the group will return to New York, sailing April 7 from Southampton on the "S. S. Liberte," or by Pan American World Airways.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

# Use of Placental Serum in the Treatment of Rheumatoid Arthritis

By MILLARD TUFTS, M. D.
Milwaukee

IT HAS been known for many years that women with arthritis experience a remission during pregnancy.[1] The development of cortisone was an outgrowth of that observation. In 1949, Granirer[2] reported favorable results with pregnant mothers' blood in rheumatoid arthritis. Stimulated by these observations, we began working with placental cord blood* in this condition and made our first announcement in December 1950 at a hospital staff meeting. In 1952, Aronson[3] reported satisfactory results with serum from placental blood in 33 patients. Others have published similar reports.[4-6]

We wish to describe our results after four years' experience with this material in 22 patients.

*Preparation.* Under sterile technic, blood is obtained from the cord, either by allowing it to run into a container or by withdrawing it with syringes. The separation is accomplished by centrifuging or by placing the placental blood in a refrigerator and letting gravity do the work. The serum is siphoned off and placed in 50–cc. containers.

*Administration.* The material may be given intravenously in 10-cc. or 5-cc. doses or intramuscularly in 5-cc. amounts. We have abandoned the intravenous route in favor of the intramuscular. The effectiveness is the same either way, but giving the material intramuscularly is simpler. Injections are made twice a week for two weeks, then once a week for eight weeks. A few patients were given freeze-dried placental blood in hard gelatin capsules orally. We also used gamma globulin made from placental blood and freeze-dried placental serum reconstituted with distilled water, intramuscularly.

Salicylates, cortisone, antibiotics, and whole blood transfusions also were used in selected patients. Other supportive measures were employed when indicated.

*Produced originally by Blood Center, Milwaukee.

## Results

Of the 22 patients, all with moderately advanced rheumatoid arthritis, 16 had major improvement, 2 showed no improvement, and 4 were slightly improved. The ages of the patients ranged from 2 years to 56 years. Remission lasted from three weeks to two years. Our results are summarized in the following table:

| | | Improvement | | | Duration of Remission |
|---|---|---|---|---|---|
| | Number of Patients | Major | Minor | None | |
| Placental blood serum only | 2 | 2 | 0 | 0 | 3 months to 2 years |
| Placental blood serum plus previous medications | 2 | 1 | 1 | 0 | 3 weeks to 1 year |
| Placental blood serum plus cortisone and salicylates for first 10 days | 9 | 5 | 2 | 2 | Average, 6 weeks |
| Placental blood serum plus physical therapy | 9 | 8 | 1 | 0 | 6 months to 2 years |
| | 22 | 16 | 4 | 2 | |

Thinking that the antiarthritic factor in placental blood serum might be in the protein of the serum, we experimented with gamma globulin extracted by electrophoresis from placental blood while waiting for our first supply of placental blood serum to be completed. Of the 24 patients with rheumatoid arthritis given intramuscular injections of this gamma globulin,** none was helped. Four of these patients were later treated with placental blood serum; two obtained major improvement.

Freeze-dried placental blood taken orally was ineffective. Freeze-dried placental serum reconstituted with sterile water and given intramuscularly was as effective as unmodified serum.

No complications, toxic effects, or withdrawal symptoms were noted. In half the patients the sedimentation rate was not reduced.

** Gamma globulin and reconstituted serum prepared through courtesy of Pitman-Moore Company, Indianapolis, Indiana, C. A. Bunde, M. D., director.

### Case Reports *

The histories of three typical patients are presented because they illustrate significant details about the course of the disease in the patient receiving placental blood serum.

*Case 1.*—A girl, aged two years, was admitted to the hospital on December 15, 1950. For several months she had been seriously ill with involvement of many joints—especially in the neck and extremities—which were swollen, stiff, and painful. She had received large amounts of cortisone. Her temperature was elevated; she had generalized edema and moon face. Her blood sugar was 150 mg. per cent, hemoglobin was 77 per cent, the erythrocyte count was 3,830,000, and the white blood cell count was 12,000, with no eosinophils. Her erythrocyte sedimentation rate was 100 mm. per hour. The blood culture was negative.

She was given salicylates, cortisone, antibiotics, and whole blood transfusions, as well as globulin made from placental blood serum; but she continued to run a septic temperature and failed to improve for 60 days. On February 8, 1951, her hips shifted into permanent flexion on the trunk, necessitating application of extension. Two weeks later her condition was unchanged, and her chances for survival were considered poor.

On February 22 placental blood serum was started along with cortisone in small doses and physical therapy. Within five weeks the patient was able to walk with assistance. Her temperature was normal most of the time. The swelling, stiffness, and pain of the joints had subsided considerably. Her hemoglobin was 91 per cent; erythrocyte count, 5,200,000; and white blood cell count, 13,350.

She was dismissed on March 25 and received placental blood serum for 20 months. Relapses were controlled with small doses of cortisone. Gold chloride was tried, but she did not tolerate it. She is now five years of age, afebrile, and free of rheumatic activity; she is undergoing orthopedic treatment for residual muscle and joint damage.

*Comment.* This patient's severe rheumatoid arthritis was considered hopeless at one time and yet responded successfully to placental blood serum. Other remedies were used, but the serum must be considered the major factor not only in her survival but in the control of the arthritis.

*Case 2.*—A 56-year-old woman entered the hospital because of moderately severe rheumatoid arthritis. Her knees, fingers, and wrists were the principal parts involved. Walking gradually had become more awkward and painful. Spindle-shaped deformities of the fingers had developed.

Various forms of treatment given during the past 15 years had afforded little relief. On May 11, 1950, placental blood serum treatment was begun intravenously; she was our first patient to receive it. Daily injections were given. On the third day of treatment, swelling of the wrists had partly disappeared and for the first time in five years, the woman was able to remove her ring from her finger. Weekly injections were given her as an outpatient, and after nine weeks the first course of treatment was discontinued. Thereafter, she received physical therapy to correct residual deformities. This patient was free from active arthritis after completing her last course of placental serum in 1951.

*Case 3.*—A 56-year-old farmer was admitted to the hospital on November 21, 1951, because of rheumatoid and osteoarthritis of the cervical and lumbar region. He received physical therapy, x-ray, and salicylates with no relief. In January 1952 his rheumatism became more active, and placental blood serum was begun. He received three injections a week, and in four weeks he began to obtain relief. In April the dosage was reduced to 10 cc. once a week. The serum treatment was discontinued on June 9, 1952. In March 1953 he reported that he had no complaints from his arthritis. Since then he has been working full time in the maintenance department of a hospital.

### Summary

Placental blood serum has been effective in the treatment of many patients with rheumatoid arthritis. It is safe and inexpensive; its collection and preparation do not require expensive equipment. Careful control of technic is needed to insure sterility. Most patients will show improvement within a few weeks after treatment is begun. The serum can be used with other forms of therapy. The ideal preparation will be a synthetic product containing the antiarthritic principle of placental blood serum in tablet form or in a concentrated solution suitable for injection.

* Placental serum used was produced through courtesy of obstetrical and laboratory departments, St. Mary's Hospital, Milwaukee.

Bankers Building, 208 East Wisconsin Avenue.

*(References listed on page 628)*

# The Management of Nonspecific Urinary Tract Infections*

By C. R. MARQUARDT, M. D.
Milwaukee

THE new chemicals and antibiotics have simplified the treatment of infections within the urinary tract. They have reduced the morbidity and mortality in urological surgery. Pyelonephritis, a common cause of death years ago, now is seldom fatal.

## Etiology

While some patients are without predisposing causes to explain their urinary tract infections, it is well to remember that there are three great contributing causes to most urinary tract infections. They are stones, stasis, and focal infection.

We have all seen patients with infections in the upper urinary tract that are the result of stones. Stasis may be produced by such conditions as cystocele, diverticulum of the bladder, prostatic obstruction, stricture of the urethra, bladder tumor, hydronephrosis with infections, and other conditions. Whenever there is a mechanical interference with the free flow of urine from one or both kidneys, infection may supervene.

The role of focal infection is probably best illustrated by the frequent occurrence of pyelitis following dysentery in infancy. Pyelonephritis often is secondary to acute tonsillitis, acute abdominal infections, osteomyelitis, upper respiratory infections, and infected teeth.

*Bacteriology.* The bacteria producing infections in the urinary tract may be divided into gram-positive and gram-negative organisms. The most common gram-positive organisms are the Staphylococci aureus and albus. Streptococcus faecalis is usually gram-positive but may be gram-negative. The most common gram-negative organisms are the Escherichia coli; Aerobacter aerogenes; Bacillus proteus; and, rarely, the typhoid or paratyphoid bacilli. In planning treatment it should be remembered that 60 to 70 per cent of all urinary tract infections are due to the colon bacillus.

## Diagnosis

It should be emphasized that, irrespective of the condition for which a patient is being treated, an attempt should be made to determine the cause of any abnormalities in the urine.

Antibiotics have eliminated the necessity for detailed studies in many patients with urinary infections; but for those with recurrent or resistant infections, every diagnostic resource is needed.

The diagnostic tests necessary for careful management of the infections of the urinary tract can be carried out in the office of the physician. He can determine the Ph of the urine and the functional capacity of the kidneys, can make intravenous pyelograms and cystograms, and can look for focal infections.

The estimation of the urine Ph is important. The majority of organisms found in acid urine respond well to treatment, whereas those that produce an alkaline urine are often the hardest to combat. Some of the drugs used to treat urinary infections are effective only in acid urine, while others act best in the presence of an alkaline medium. The urinary output is a rough guide of the functional capacity of the kidney. If the patient's output is two-thirds his intake, the function of his kidneys is usually good. The measurement of specific gravity of the urine is a simple test and is a reliable index of kidney function.

To determine the presence of pus in the urine is simple, but it should be emphasized that incorrect diagnosis may originate from a poorly collected specimen. The voided urine from the female always contains bacteria and may contain pus from the cervix, vagina, and the adjacent glands. For this reason only the catheterized specimen in females gives reliable information. Urethritis, prostatitis, and seminal vesiculitis in males may account for pus found in the first portion of a voided specimen. Therefore, only the last portion of a two-glass test should be used for microscopic studies.

While the inspection of the gross specimen of urine is not too important, it does give some measure of the degree of infection present. Whenever a urine is milky due to the presence of pus, one can be reasonably sure that either pyonephrosis or diverticulum of the bladder is present.

*Read at Washington–Ozaukee County Medical Society meeting, July 22, 1954.

An attempt should be made to define the bacteriological flora of the urine. This may be accomplished by a gram stain. It will indicate whether the infection is bacillary or coccal, gram-negative or gram-positive. In the majority of cases, more complicated bacteriological study is not necessary. If the facilities are available, cultures and sensitivity tests should be done when the more recently available urinary antiseptics are to be used. Thus, one is able to determine the most effective of these antiseptics to use before treatment is instituted. We are seeing more and more urinary tract infections that are completely resistant to all antibiotics, or at least sufficiently resistant to a large number of them that a patient may be on treatment for a number of months before a proper drug is selected.

It is not suggested that every patient with infection of the urinary tract be subjected to a complete study of this tract, including cystoscopy. However, the persistence and recurrence of infections are often results of such complications as obstruction, calculi, and tumors.

### Treatment

Patients who have systemic manifestations of urinary tract disease should be at bed rest, in the hospital if possible. In the presence of sepsis, catheterize only when necessary for drainage. Delay diagnostic studies involving instrumentation until the sepsis is controlled.

The fluid intake should be 3,000 to 4,000 cc. in 24 hours. If the patient has fever, or if there is stasis of urine, it is expedient to insert an inlying urethral catheter in order to give more adequate and direct drainage of infected urine away from the body. This is particularly true in patients who have obstructive diseases, although I have employed catheter drainage on many occasions when there was no demonstrable urinary tract obstruction present. In pyelitis of pregnancy, inlying ureteral catheters may be more effective. Focci of infection in the teeth, tonsils, sinuses, cervix, and prostate should be treated, as they may be contributing factors. Once these are eliminated, the urinary infections should respond in the same manner as they do in patients without urinary complications or focci of infection.

*Drugs.* Mandelic acid, sulfonamides, Furadantin, penicillin, streptomycin, Aureomycin, Chloromycetin, Terramycin, and erythromycin are the preparations most commonly used to treat urinary tract infections.

*Mandelic acid* is effective against the majority of bacillary infections of the urinary tract associated with an acid urine. It is almost specific for infections due to the Streptococcus faecalis, but is not efficient in the treatment of most coccal infections. It is most effective when the Ph of the urine is 5.5 or below. The desirable degree of acidity of the urine may be maintained by the administration of ammonium chloride or sodium acid phosphate. Mandelic acid may be administered in the form of the elixir or the syrup. The adult dose of the elixir, which contains 26 per cent of the drug, is one tablespoon four times daily; and the dose of the syrup, which contains 40 per cent of the drug, is two teaspoons, four times daily. The period of administration of mandelic acid should be from ten days to two weeks. If improvement does not occur within this time, another preparation should be substituted. The urine should be examined at frequent intervals; and administration of the drug should be discontinued if albumin, red blood cells, or casts are found within urine that has not contained these elements previously.

The *sulfonamides* most widely used are sulfadiazene and Gantrisin. The sulfonamides have advantages over mandelic acid in the treatment of urinary tract infections. They are effective against the majority of gram-negative bacilli which invade the urinary tract and against most of the gram-positive cocci, with the exception of the Streptococcus faecalis. Moreover, they can be used in the treatment of both acute and chronic infections. Finally, they are effective in both acid and alkaline urine. However, it is safer to keep the urine alkaline during the period of administration of one of the sulfonamides. They are readily absorbed in the gastrointestinal tract and eliminated chiefly by the kidney. In patients with normal renal function the therapeutic concentration of the drug is readily obtainable. Therefore, large doses are not necessary in the management of uncomplicated urinary infections. The usual dosage is 0.5 to 1.0 Gm., four times daily.

Most sulfa reactions are not significant, but many are. Digestive disturbances, malaise, urticaria, and fever are the most com-

mon reactions. The anemias produced by some of the earlier derivatives rarely result from the preparations now in use. If febrile reactions occur, it may be difficult to decide whether they are caused by the drug or the infection. If the drug is causing the reaction, the white blood cell count will be normal or below, and the temperature promptly returns to normal as the use of the drug is discontinued.

Most important are the kidney reactions to the sulfonamides. They are of two types. The most frequent is the formation of crystals in the urine. Precipitation of these in the renal tubules may produce considerable reaction in the excretion of urine, or anuria without pain. In such cases use of the drug may be discontinued; and administration of an adequate amount of fluid, with alkalinization, will usually accomplish an adequate result. If crystals are precipitated below the papillae, they may accumulate in sufficient amounts to produce renal colic and may occasionally block one or both ureters. This is manifested by a ureteral colic, with all the signs of renal obstruction. These patients require catheterization in addition to the administration of fluids and alkalis.

The other reaction is degeneration of the renal tubules, with pathological changes in the kidney. Such reactions cannot be anticipated, but adequate preliminary study and careful observation while the drug is being given should prevent most of the more serious complications. A daily intake of 3,000 cc. of fluid, combined with the use of small doses of sulfonamides in the treatment of urinary infections, probably offers the greatest assurance against a severe toxic reaction. The urinary output must not be allowed to drop below 1,000 cc. in 24 hours. If crystals appear in the urine during sulfonamide therapy, and particularly if there is gross hematuria and a reduced urinary output, the therapy should be promptly discontinued. Reduced renal function does not necessarily contraindicate the use of sulfonamides, but more careful supervision is required during the period of administration. If a perceptible improvement is not noticed within the first week of treatment as determined by microscopic study of the stained specimen, other urinary antiseptics should be substituted. It would seem that the various combinations of sulfonamides now available possess no therapeutic advantage over the single drug, unless one considers the combination of sulfonamides with some of the antibiotics.

*Penicillin* is not suitable for routine use in the treatment of common urinary tract infections. It has no effect on bacillary infections but is effective against many of the infections of the gram-positive group. Some organisms have the ability to produce an enzyme penicillinase, which inhibits the action of the drug. In acute infections due to gram-positive cocci which are known to be sensitive to penicillin, satisfactory results may be obtained. The fact that it is best given intramuscularly, however, renders it less practical than the other urinary tract antiseptics in the treatment of the ambulatory patient.

Approximately one-half of the patients with uncomplicated infections of the urinary tract due to the colon bacilli are cured by the administration of *streptomycin*. This has the disadvantage of obscuring tuberculosis. Infection due to the Proteus ammoniae and Aereobacter aerogenes also responds well to this drug. The gram-positive cocci, however, are best treated by other preparations. Because streptomycin is not absorbed from the gastrointestinal tract, it must be administered parenterally. In many cases, the intramuscular administration of 0.5 Gm. every 12 hours for 7 to 12 days will cure the infection if the invading organism is streptomycin sensitive. However, because many bacteria alter their sensitivity to streptomycin after long exposure, better results will be obtained if larger doses are given after the first days. It is best to determine the sensitivity of organisms to the drug before treatment is started. The usual reaction to streptomycin is mild and unimportant. Such symptoms as flushing of the face, numbness, and nausea, which may occur following the injection, promptly disappear after the administration of the drug is discontinued. However, the more serious reactions of tinnitis, vertigo, impaired hearing, and renal damage may persist for months after treatment is discontinued. Like penicillin, streptomycin has the disadvantage of requiring intramuscular administration at rather frequent intervals; and for that reason its use is confined chiefly to hospitalized patients. A preparation containing both penicillin and streptomycin is now available; like the single preparation, it must be given

by intramuscular injection. This mixture may be indicated in cases of mixed infections of the urinary tract.

*Aureomycin, Chloromycetin, and Terramycin* may be considered together. They are effective against the majority of organisms which invade the urinary tract, although they are less effective against the focal infections than is penicillin. Directly absorbed from the gastrointestinal tract, they appear in the urine in sufficient levels within one hour after administration. Since Chloromycetin is more rapidly absorbed and excreted than any of the others, it must be given at more frequent intervals in order to maintain therapeutic levels of the drug in the urine. Aureomycin is more slowly excreted. Bacteriostatic levels have been noted in the urine as long as 30 hours after the use of this drug has been discontinued. The usual dose of these drugs is 50 to 250 mg. at six-hour intervals.

*Achromycin and erythromycin* might also be considered with this same group of drugs. Erythromycin has the advantage of being particularly effective against the Staphylococcus aureus. The toxic reactions to the molds are most important; they are almost entirely systemic. The most common are those referable to the gastrointestinal tract. Abdominal cramps, diarrhea, nausea, vomiting, stomatitis, and ulceration of the entire gastrointestinal tract may occur at times. This is particularly true with the use of Aureomycin, Chloromycetin, Terramycin, and Achromycin.

*Furadantin* may be employed in the treatment of urinary tract infections; and where organisms are sensitive, it is effective. It may produce testicular damage.

*Aureomycin and Terramycin* may produce death by alteration of the bacterial flora of the intestinal tract. It might be said that if infections do not respond in 48 hours, they are probably resistant.

Whenever molds that are apt to produce a sterilization of the gastrointestinal tract are used, care should be exercised and treatment promptly discontinued if diarrhea occurs. In the treatment of the patient with a urinary tract infection and fever, it is well to keep him at rest until he has been afebrile for a period of at least 24 hours. It is also advisable to continue to observe the urine at frequent intervals to see that sterilization of the urine has occurred. Every therapeutic effort should be employed for several weeks. If the gram stain still shows presence of pus and bacteria at the end of this time, treatment should be continued. If, however, the urine is microscopically normal, it is well to have a culture following the cessation of all treatment to determine whether or not bacteria are still present. If a positive culture is secured, it is well to continue treatment until a negative culture is obtained. In some patients this is never accomplished, and such patients may have recurrence of symptoms shortly after cessation of treatment. These patients may commonly employ a small dose of an effective drug over an indefinite period of time. Many people have taken one or another of the sulfonamides during a period of several years without any ill effects.

## Summary

1. Each patient with a urinary tract infection should be adequately studied to determine whether focal infection, stasis of urine, or stone may be the cause of the infection.

2. The patient should receive adequate fluid intake, and frequent urine studies are advisable.

3. Intravenous pyelography is a valuable screening procedure in patients with urinary tract disease. However, we must be aware of its limitations. Renal tumors, bladder tumors, tuberculosis, and nonopaque urinary tract stone may be overlooked or not clearly defined.

4. Instrumentation of patients with acute urinary tract infections is not advisable except to facilitate urinary drainage.

5. Bed rest is desirable for all febrile patients.

6. Treatment should be continued long after the patient is relieved of symptoms and until the urine is negative to cultures without the use of a urinary antiseptic.

7. The best results are secured when the drug used in the treatment of infection is demonstrated by sensitivity test to be the most effective.

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# Hazards in the Use and Formulation of Insecticides*

By FRANK PRINCI, M. D.**
Cincinnati, Ohio

BECAUSE of the relatively recent, and yet tremendous, development of the newer insecticides, one does not see this subject on many medical programs. I shall not discuss the importance of insecticides from the point of view of public health, or the use of insecticides in increasing crop production throughout the world, since these are rather well known. It should be realized, however, that so effective have the modern insecticides become—and by modern I mean those developed since World War II—that in some parts of the world malaria is practically unknown. Of course, this merely means that we add to the population of the world; therefore, we make greater demand on the food supply, and so we need more insecticides to prevent destruction of this food supply.

So important has this activity become that in the past ten years several thousand million pounds of organic materials have been produced for use as insecticides. These materials are used not only in the fields and in many geographic areas to control disease vectors, but also in the home. The use of these substances, therefore, is developing rapidly. Forty-eight hours after this talk has been given, a new insecticide will no doubt have been added to the long list that already exists. For that reason I can do no more than to divide these materials into two general groups and to ascribe to these groups certain general characteristics of physiologic activity.

### Two Groups of Insecticides

The two general groups of organic insecticides are the organic phosphate compounds and the chlorinated hydrocarbon compounds. Both of these have been known for many years as nerve gases, and it is now popular when discussing them in newspapers and in the magazines to call them the substances which are used as nerve gases. It is only proper to state, at this point, however, that they have not been found to be useful as "nerve gases." They do have certain characteristics in common with nerve gases. The materials can be absorbed through the respiratory tract, through the gastrointestinal tract, and through the intact skin. As you know, there are various other substances which are absorbed through the intact skin. All the organic insecticides can be absorbed in that fashion.

At the onset I would like to suggest that when any of these materials produces a clinical reaction, we do know, in general, what to expect. This is true of most therapeutic and nontherapeutic drugs in medicine. I make a point of this fact because at times we are so completely led astray by a history of exposure to a toxic material. It is too easy to forget the application of common sense. We forget that for every action there is an equal and opposite reaction; and we forget, therefore, that a certain drug can be expected to produce a certain reaction. If some other type of reaction has been produced, the substance to which the patient has been exposed is probably not the offending agent. It is true, of course, that, with every material, some persons are hypersensitive and some persons are extremely resistant; but these are the exceptional cases and are not common. For example, if we give ten persons an adequate dose of a barbiturate, we would expect at least nine of them to go to sleep. If all ten fail to go to sleep or to show manifestations of sleepiness, the chances are that the agent given was not a barbiturate. I would like to think of all intoxicating materials in much the same fashion. If a person has been exposed to some insecticide and becomes ill, the signs and symptoms must be consistent with those which are known to be produced by that material; otherwise, the diagnosis should at least be delayed.

### Investigation in Animals

Much of our information concerning the physiologic effects of the absorption of deleterious materials comes from the toxicologist, who applies these materials to animals and observes the reaction. All animals do not react in the same way to the same things.

*Presented at Industrial Health Clinic, Milwaukee, May 5, 1954.

**Associate Professor, Industrial Medicine, University of Cincinnati.

Since there are such mechanisms as detoxification, the body has developed through evolution various systems of detoxification, particularly for organic materials. These systems of detoxification, unfortunately, are not the same in all animals; they vary frequently. Animals differ from one another structurally. That presents one of the dangers in translating the things we see in animals in terms of human beings, particularly when we are thinking in terms of dosage. In this area, therefore, many great errors may be made. If we interpret merely the effect of large dosages on certain organic systems, we are on fairly safe ground; but when we attempt to interpret the consequences of relative dosages, we enter into definite fallacies, particularly with regard to man. Finally, of course, what we see in the animal are clinical signs, many of which we don't understand. We don't see symptoms; and the animal, of course, cannot report symptoms. This is a very important concept, and it must be appreciated fully.

Animal investigation is extremely important, however; since most of the materials in the insecticide field today have produced so little human intoxication that has been recognized and that has come to the attention of the average practitioner, it has been essential to conduct much laboratory research. Experts who attempt to interpret what has happened in the animal in terms of what might occur in humans must, of necessity, have knowledge of both types of biologic mechanisms.

### Exposure in Human Beings

At this point it should be emphasized that there have been cases of intoxication among humans and that there will be more such cases, particularly because of large amounts of insecticides which are being used and which will be used, not only in agriculture, but also in the home. This summer additional chlorinated hydrocarbon insecticides may be labeled for domestic usage, which means that they can be purchased in local retail stores. Persons will use these materials; they will become ill from any cause, and invariably questions of intoxication by an insecticide will arise.

First, it should be made clear that exposure to an insecticide or any other material does not produce immunity to systemic disease of other types. Second, in accordance with the basic principles of industrial medicine, when one thinks in terms of exposure, clinical response is a definite function of time times dose. In the presence of a history of an inadequate dose over an inadequate period of time, some other etiologic agent must be sought. In the case of most of these materials, unfortunately, diagnostic laboratory tests do not exist. There is not a simple way of determining what is in the blood or urine, and the metabolic breakdown products are not known.

It is impossible to make a diagnosis from the laboratory without seeing and understanding the clinical syndrome. As doctors, we are accustomed to looking for signs and symptoms. If the signs and symptoms are consistent with what we know usually happens with those individuals who have been exposed to these materials, we are justified in making a diagnosis. If, on the other hand, the signs and symptoms are entirely different, we are at least justified in holding our diagnosis in abeyance so that serious mistakes are avoided. Such a mistake was made the other day when I discussed a case with an individual who was not a general practitioner but who had had a great deal of experience in industrial medicine. He reported the case of a patient who had died a month after spraying a set of drapes with a certain chlorinated hydrocarbon insecticide. He had sprayed for two days; and when inquiry was made concerning his symptoms, the reply was: "What difference does that make; he had sprayed for two days." Since these materials are mixed in specific concentrations and with certain vehicles, it is essential to know exactly what occurred during the exposure. And, indeed, symptoms do make a difference in any disease. These diagnoses cannot be made with a wave of the hand or by some superior genius. There is little in the field of medicine that has been accomplished without hard work and intelligent investigation.

### Organic Phosphates

Until very recently I was not aware that any of the organic phosphates were used in the home. Since that time, I have seen two cases of intoxication in children by these materials, so it is apparent that they can be purchased in retail stores in certain states, although perhaps not in your own. These materials are called the cholinesterase inhib-

itors. When there is a history of an ingestion of the material, the diagnosis is relatively simple. The label on the package will usually define the material. The physiologic response to the ingestion of these materials or to the absorption of high amounts suddenly will be one of central nervous system stimulation. There will be convulsions; and soon after the convulsions, pulmonary edema will ensue. The materials themselves are not irritating. Pulmonary edema is produced by bronchospasm and by the convulsions. There will be a sudden drop in the cholinesterase level of both the red blood cells and the serum. With a history of exposure and the presence of convulsions with pulmonary edema and an extremely low blood cholinesterase or serum cholinesterase, there can be little question of a definite diagnosis of phosphate insecticide intoxication.

Another problem arises when the person has been exposed for a long period of time to a very small concentration. This, of course, rarely occurs in the home; but it does occur in the fields. It happens particularly among those who spray orchards and fields. Organic phosphates have a low residual, which means that a short time after the spraying has occurred the material is no longer present on the fruit. Spraying is done both by hand and by machine and also by airplane. The greatest hazard is in walking through fields that have been sprayed recently. Most persons who use the material are aware of the hazard; they will not spray directly into their own faces, nor will they walk down wind from a spraying area. Pilots, however, are known to be a little more careless; and they are likely to fly through a swath which has just been laid down. These hazards can all be controlled readily by impervious clothing and by respirators.

The greatest hazard of insecticide absorption is in the formulation of the compounds. Formulating plants exist throughout the country, and they mix a wide variety of insecticides. They not only mix individual compounds, but they also mix them with other insecticides and with other materials. Thus, a material may have a greater percentage of DDT than of anything else, and yet it may also contain an organic phosphate or other substances. There are many good reasons for these mixtures, but it is well to know that an exposure may not be just to a single material. In addition, materials such as xylol, which is intoxicating in itself, may be used as vehicles.

Atropine is the drug of choice in the treatment of phosphate insecticide intoxication. Proper treatment consists of the administration of atropine together with the administration of oxygen, preferably under pressure. When patients are placed in an oxygen tent, they may develop pulmonary edema very rapidly and not do well. As you know, an oxygen tent rarely provides more than 30 to 35 per cent oxygen. Since the oxygen from the ambient air is roughly 21 per cent, the tent does not provide a significant increase. When oxygen is administered under pressure, however, the development of pulmonary edema is retarded and improvement is more rapid.

### Chlorinated Hydrocarbon Insecticides

The chlorinated hydrocarbon insecticides are more commonly used than any of the other insecticidal materials. These vary mostly in their breakdown products and the metabolites which are produced. Fortunately, they vary little in their physiologic action, although the dosages required to produce the action vary. Some of them are more potent insecticidally than others, and it is apparent that the more potent one will have the widest use. For example, it takes roughly a pound of DDT per acre for locust control; and with one of the newer substances, just two ounces per acre will provide adequate control. This quality of the material reduces shipping costs and makes a more profitable substance for use and for sale. In the manufacture of these compounds, interestingly enough, there is very little hazard. The operation is closed in type, and it is carried out mostly in reactors. The workmen have very little exposure, if any. There is some exposure in the packaging, but even that is minimum. Thus, even the most toxic compounds can be manufactured without any serious or uncontrollable industrial hygiene problem.

The greatest problems again arise in the formulation of the compounds. They are mixed either indoors or outdoors. Some farmers buy them and mix them themselves, but usually they are purchased by formulators who wholesale them. The formulator, if he has a large business, has a clean plant with good housekeeping; but most formula-

tors have small businesses. They are small because the work is seasonal and is dependent entirely upon the weather and the insects.

The chlorinated hydrocarbon insecticides taken or absorbed in large doses will produce loss of appetite, hyperexcitability, hyperirritability, and convulsions. The convulsions, however, are different from those found with the phosphates because pulmonary edema is not a serious problem; however, it may occur. The convulsions begin two to four hours after the material has been absorbed.

Although these materials have then been called insidious, there is no clinical evidence to substantiate this impression. If a physiological dose is taken, the response will be prompt and adequate; and it occurs, in general, within two to four hours. A latent period as long as six hours has never been reported. The patient will have his first convulsion, therefore, two to four hours after the material has been absorbed; and the convulsions will probably last from two to four minutes. There will be a remission of from ten to thirty minutes between convulsions. During this time the patient will lie in a semistuporous state and be somewhat incoherent. However, hyperexcitability remains; and if the patient is slapped or if a loud noise is made, he will go into another convulsion. This phenomenon is also seen in animals, but the animal convulsions are somewhat different.

How long the convulsions will continue depends upon how much of the material has been absorbed. They may remit spontaneously within 24 hours. However, if a very large dose has been taken, they will not cease and the patient may go into a coma and die. With most cases, if the patient receives adequate treatment promptly, he will recover.

The treatment of choice is the administration of barbiturates. Morphine and morphine derivatives are contraindicated. Any barbiturate may be used. Preferably, the initial dose should be given intravenously and the second intramuscularly; and oral administration is advisable when the patient can accept it. There is very little danger in giving barbiturates, even in high doses; and one must give a sufficient amount to control the convulsions. In every instance of chlorinated hydrocarbon intoxication, and there have been many, both by suicidal intention and by accidental ingestion, complete recovery has been the rule; and there have been no sequellae.

The clinical picture, however, may be rather inconsistent. There is an immediate rise in white blood cell count, with a shift to the left of the differential; there is an immediate rise in blood pressure. Both of these return to normal within 48 hours if the convulsions have been controlled properly. An increased coproporphyrin excretion in the urine may be expected because these materials do affect the liver.

In the more serious cases there is a change in the electroencephalogram characterized by diffuse cortical stimulation which is the same as that seen in epilepsy. In fact, these electroencephalograms cannot be differentiated from those of epileptic patients, except that the electroencephalogram of the chlorinated hydrocarbon insecticide case will return to normal within six months, whereas that of the epileptic patient will not. In addition, during the convulsions the intoxicated patient has not been known to bite his tongue or otherwise incur physical injury.

These are the acute symptoms. It is interesting to note that in cases of such intoxication, with very few exceptions (and those were suicides), complete recovery has been the rule. We have some cases which occurred five years ago; these patients have shown no sequellae of any type.

Finally, the last question concerning the chlorinated hydrocarbon insecticide is that of chronic intoxication. Chronic intoxication is a confusing term because it means so little; I would like to change the term to chronic exposure, or chronic absorption of small amounts. These compounds do produce a clinical response. The patients may lose their appetite and therefore lose weight, and the loss of weight is concomitant with and directly proportional to the loss of appetite. There is no magic quality about these substances which produces a loss of weight independently of the anorexia.

In animals the liver function tests show abnormal results, but in humans the results are normal; and by the time they become normal, there will have been prior clinical evidence of this disorder. There is no change in the red blood cell count or the white blood cell count. The patient may have headaches and insomnia.

Thus, a patient with headaches, insomnia, and loss of weight should always be removed from exposure. If the situation has been caused by chlorinated hydrocarbon insecticide exposure, recovery will take place rapidly. As with all other industrial exposure, the first step in treatment is removal from the exposure. When airplane pilots are involved (and much of this material is sprayed by airplane), it is best to keep them from flying, regardless of whether their symptoms are due to absorption of the substance they are spraying or not.

I have described these substances as systemic poisons, and that is precisely what they are. One other question that will arise frequently is whether these materials cause dermatitis. The facts are that these chlorinated hydrocarbons are not primary irritants nor are they known to be sensitizers. There is no doubt that, in an unusual instance, anyone might become sensitive to almost any substance; but sensitization is so uncommon as to be relatively unknown.

### Summary

In summary, I would like to say that with the millions of pounds of these materials that have been used since 1945, we have had fewer cases of intoxication by organic insecticides of all kinds than by the inorganic insecticides which we used prior to World War II. This does not mean that the newer insecticides will not produce intoxication, but it does mean that because of proper understanding on the part of the users and proper methods of application, they can be used safely.

It is very simple to say these compounds are diabolical; and since they are used as poisons and actually manufactured as such, there is more reason to suspect them. That, too, is good. But in the interest of good diagnosis, in the interest of a common-sense approach to a very difficult problem, I suggest that these materials are definite and specific in their action; therefore, they can be properly appraised and controlled with intelligence.

## CONTINUATION COURSES SCHEDULED AT UNIVERSITY OF MINNESOTA

The University of Minnesota has announced the following continuation courses to be held at the Center for Continuation Study during the first part of 1955:

**January 31–February 4**—Courses in ophthalmology and otolaryngology for specialists in those fields. Physicians may register for one or both courses. Guest speakers in ophthalmology include Dr. P. J. Leinfelder, Professor of Ophthalmology, Iowa State University, Iowa City, Iowa, and Dr. Frank Newell, Associate Professor of Ophthalmology, Northwestern University Medical School, Chicago. In the otolaryngology course, speakers include Dr. Howard House, Associate Professor of Otolaryngology, University of Southern California, Los Angeles, and Dr. Peter Pastore, Professor of Otolaryngology, Rhinology, and Laryngology, University of Virginia Medical College, Richmond, Virginia.

**February 14–16**—Recent Advances in Internal Medicine. The course will deal with various aspects of hematology, cardiology, endocrinology, and respiratory physiology.

**February 17–19**—Cancer Detection for General Physicians. This course is presented jointly by the University of Minnesota and the Minnesota Division of the American Cancer Society and will consist of a series of lectures and informal discussions concerning cancer detection technics. Those wishing to observe and participate in certain examination procedures will be given an opportunity to do so.

**February 28–March 2**—Clinical Hematology. Registrants will be provided with slides for study showing examples of various blood cell types and of the more frequent hematological diseases. Lectures will include discussions of the anemias, the leukemias, and coagulation defects.

# Wisconsin Anesthesia Study Commission of the Wisconsin Society of Anesthesiologists

Editor—DOROTHY W. BETLACH, M. D., Janesville, Wisconsin

## Incompatible Blood Transfusions

Approximately one of every five patients admitted to a hospital today receives a blood transfusion. This valuable therapeutic agent is no longer considered an emergency "last-stand" procedure. Because of their easy availability, however, there is a growing tendency to accept transfusions as routine, simple, and harmless medications. Every transfusion is a potential sensitizer, and incompatible transfusions may cause death. Blood should not be given unless a real indication exists.

Major incompatibilities are an ever-present hazard. A reaction, more severe in some cases than in others, occurs in every 250 transfusions. Even in the best run laboratory an occasional mistake may be made, since the possibility of "human error" cannot be completely eliminated. The chief sources of error are the use of low-titer typing sera, which may result in mistyping, and clerical mistakes in the actual handling of the blood.

The technical staff of a blood bank must assume responsibility for collection of blood from donors and dispensing of it for recipients. Only by such assumption will the gravity of the situation be impressed upon them. Incorrect labeling of bottles, especially pilot tubes, and distribution of blood to the wrong recipient should be prevented entirely.

The use of high-titer grouping sera is essential for accurate determination of blood groups. Detection of the most significant antibodies is dependent upon the use of a standard cross-matching technic which is readily performed and of high sensitivity. The test described by Hunter is presented in detail:

Use appropriate blood type and Rh group for cross match:

A. Donor's cell suspension—2 per cent cells *in donor's serum* or 6 per cent albumin; *never use* saline as a medium
B. To 2 drops of patient's serum, add 1 drop of donor's cell suspension. Use a clean test tube such as a Kahn tube
1. Place tube in water bath at 37 C. for at least 30 minutes
2. Remove and centrifuge at 1,500 r.p.m. for 1 minute
3. Remove tube and carefully observe the packed cells for clumping by gentle shaking. If in doubt, observe the packed cells through a microscope

Close, continuous observation of the recipient during a transfusion will also help detect early reaction and incompatibilities. In the conscious patient administration of small amounts of incompatible blood will usually cause immediate symptoms. The earliest complaints are anxiety, chilling, a sensation of constriction in the chest, and generalized discomfort. Pain in the lumbar area, associated with chills and high fever, usually develops; and signs of shock may become evident. A late sign is hemoglobinemia, followed by jaundice, oliguria, uremia, and death.

When incompatible blood is given to a patient during general anesthesia, however, there are very few signs and symptoms to indicate that anything is wrong. Severe drops in blood pressure and uncontrollable oozing from the surgical wound have been noted. For this reason blood should be administered during anesthesia for specific indications only and the patient observed very closely for the earliest possible sign which might indicate a reaction.

Specific therapy for hemolytic transfusion reactions has been confined to urinary alkalinization, retransfusion with compatible blood, and general supportive treatment. The exact mechanism of the anuria is not thoroughly understood, and approximately 50 per cent of the patients sustaining a true reaction from incompatible blood do not survive. The administration of blood should be stopped immediately on the slightest suspicion of a reaction and investigation started to determine the cause of the reaction. Early treatment is essential.

CASE 58.—A 15-year-old male was admitted to the hospital after a motorcycle

accident. Bilateral trephination was done immediately for severe edema of the brain. There was some improvement, but about a week later the patient began complaining of headache. An encephalogram demonstrated an expanding type lesion on the left side of the brain, and two days later the patient was prepared for exploration.

One hundred milligrams of pentobarbital, 0.45 mg. atropine, and 50 mg. meperidine were given one hour before anesthetization. Induction was accomplished with 1 per cent thiamylal given intravenously, and anesthesia was maintained with nitrous oxide-oxygen in a 50–50 mixture on a semiclosed system. The trachea was anesthetized with 4 cc. of 4 per cent cocaine applied topically; and 15 minutes after induction, a No. 9 cuffed Magill endotracheal tube was inserted. The patient's blood pressure at that time was 130/90, and the pulse rate was 72.

A left-sided trephination was performed, and an epidural collection of old blood was evacuated. The procedure lasted an hour and 20 minutes, and during that time the blood pressure gradually increased to a level of 170/30 and the pulse rate was 80. When the patient was returned to his room, the blood pressure was recorded at 160/90. During the operation he received 1,000 cc. of 5 per cent glucose in distilled water.

Shortly after he was returned to his room, a transfusion of 500 cc. of whole blood was ordered and started. About four hours later it was noted that the operative site beneath the bandages was markedly swollen. The patient was semicomatose, and his temperature was 104 F. The blood pressure was 200/90, and the pulse rate was 82. The blood transfusion was finished, and an intravenous solution of normal saline was being administered.

He was returned to the operating room and reanesthetized. Nitrous oxide-oxygen in a 50–50 mixture was again administered by semiclosed endotracheal technic. At this time it was reported that the patient had been catheterized prior to his return to the operating room and that the urine contained blood. The laboratory obtained another blood sample from the patient for retyping and recross-match, and it reported that the patient's blood was Group B. The blood which had been administered had been Group A. The saline and intravenous tubing containing the remains of the blood transfusion were immediately discarded, and an intravenous infusion of 500 cc. of dextran was started. The patient was given an intravenous injection of 100 mg. cortisone intramuscularly, and 500 cc. of lactate Ringer's solution in 5 per cent glucose was also given. A bottle of Group O blood containing Witebsky factor was started following the dextran.

A large subcutaneous hematoma was evacuated, and during that time the patient's blood pressure ranged between 115 and 130 systolic and 90 and 110 diastolic; and the pulse rate was between 120 and 130. He frequently "bucked" on the endotracheal tube and moved a hand or a foot. When he was returned to his room an hour and one half later, his blood pressure was 130/90 and the pulse rate was 120. Subsequent therapy consisted of alkalinization of the urine for two days and supportive therapy. He improved steadily and was discharged two weeks later.

Case 59.—X-ray studies of the spine of a 39-year-old male revealed spondylolisthesis, with an unfused isthmus of the fifth lumbar vertebra. Surgical fusion was recommended. The patient's general physical condition was excellent. Blood pressure was 110/50.

Two days after admission a spinal fusion was performed. Anesthesia consisted of intravenous meperidine and endotracheal nitrous oxide, and maintenance was uneventful. Toward the end of the operation, 500 cc. of blood was started intravenously, although blood loss was considered moderate. Thirty minutes later the blood pressure dropped from 110 to 70 systolic, and the pulse rate increased to 140. A second 500 cc. of blood was started.

The patient was kept in the operating room for observation because of the unstable blood pressure. It was noted that the bandages were soaked with blood, and inspection of the operative wounds revealed marked bleeding. Thromboplastin was inserted into the areas and pressure was applied, but bleeding continued. The wounds were opened, but no bleeders were found. Steady oozing continued, and the wounds were closed and pressure dressings applied. 2,500 cc. of blood and 1,500 cc. of plasma were administered. Blood pressure was 100/60.

That evening the patient became apprehensive; his respirations were rapid, and the heart rate was 156. Moist rales were heard throughout the lung fields, and the patient became cyanotic. Tourniquets were applied

to all four extremities, and he was digitalized. Shortly thereafter he became anuric.

On the first postoperative day the patient appeared improved. Color was good, respirations and heart rate had decreased, and no rales were heard. Jaundice of the sclerae was noted. A serum specimen showed marked hemolysis, and a new sample of blood drawn from the patient was found to be type O rather than type AB. The patient remained anuric and became weaker. Carbon dioxide combining power decreased, and soda bicarbonate was given orally. Five hundred cubic centimeters of type O blood was administered on the third postoperative day; and several days later a hemoglobin determination showed 11 Gm., in contrast to a previous reading of 8.5 Gm.

On the sixth postoperative day the patient was hyperpneic, and percussion of the right chest indicated complete consolidation. Carbon dioxide combining power had dropped to 31.36. Oxygen by nasal catheter was started, with some improvement in respiration. Blood pressure was 80/40. Several hours later the patient developed severe dyspnea, rapidly followed by coma, vascular collapse, and death. Autopsy revealed a lower nephron nephrosis and massive pleural effusion on the right.

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It is difficult to identify any specific signs which indicated a transfusion reaction in the first patient. The age of the patient and his excellent physical condition probably had much to do with the fact that the outcome was favorable in spite of his receiving 500 cc. of mismatched blood.

In retrospect it is relatively easy to pick out warning signs of trouble that occurred in the second patient following administration of the first bottle of blood which was incompatible. Blood pressure fall, tachycardia, and severe oozing from the surgical wound were probably due to the reaction. Unfortunately, these signs were interpreted as signs of shock; and more incompatible blood was given. Further investigation revealed that the initial blood sample for typing and crossmatching was mislabeled on the ward.

The seriousness of blood transfusions cannot be overemphasized. Every individual concerned in any way with the production and administration of a single bottle of blood must assume responsibility and vigilance. Only in this way can errors, with their tragic results, be prevented.

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## AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY EXAMINATION

The next scheduled examination (Part I), written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada, and military centers outside the continental United States on Friday, February 4, 1955.

Case abstracts numbering 20 are to be sent by the candidate to the Secretary, Robert L. Faulkner, M. D., 2105 Adelbert Road, Cleveland 6, Ohio, as soon as possible after receiving notification of eligibility to the Part I written examination.

# Clinicopathologic Conference

Editors—D. M. ANGEVINE, M. D., University of Wisconsin Medical School, Madison, and
J. F. KUZMA, M. S., M. D., Marquette University School of Medicine, Milwaukee

## REPORT OF A CASE*

*History:* This 83-year-old white, married, retired farmer was admitted to Wisconsin General Hospital for the first time on February 26, 1954. His chief complaint at the time of admission was vomiting.

For 8 to 10 years prior to admission the patient had had frequent episodes of vomiting, especially following the ingestion of large quantities of cold water. For several years prior to admission he had experienced generalized epigastric and abdominal distress following meals. This did not happen after every meal, but it did occur with moderate regularity, especially when he ate larger quantities of food. For two years prior to admission the patient had noticed increasing constipation and had resorted to taking "Epsom salts." He had never noted the nature of his stools and therefore did not know whether he had had rectal bleeding or had ever had melena. Two nights prior to admission he had taken a laxative and as a result had been in considerable distress all that night and all the day prior to admission. He had had one small bowel movement since the ingestion of that laxative. In the afternoon of the day prior to admission he had developed some midabdominal pain and had started vomiting. After repeated vomiting the vomitus had become "coffee ground" in nature, and the patient had continued to vomit repeatedly all during that night.

The morning of admission the patient was brought to this hospital in an ambulance and during the ride to the hospital continued to have repeated episodes of vomiting of coffee-ground material. No other definite symptoms referable to the gastrointestinal system could be elicited. There was no definite history of previous anorexia, jaundice, or abdominal pain suggestive of a peptic ulcer or gallbladder disease. Past health and illness and review of systems were essentially noncontributory. The cardiorespiratory systems were essentially negative, especially for a man of this age. The genitourinary system was essentially noncontributory; there was a nocturia of 2 to 3 times per night, but there were no other positive symptoms. There was a history of some recent weight loss; the exact amount was unknown to the patient. The personal history was noncontributory. The patient had been married 52 years, and his wife was in good health. He had been a farmer all his life and had not had any occupational exposures.

*Physical Examination:* This examination revealed a well-developed, fairly well-nourished, old, white male who was in no acute distress. He was somewhat confused and rambled on a great deal during his interview; therefore, his history was somewhat unreliable.

The blood pressure was 110/70; the pulse, 78; respirations, 18; and temperature, 98 F. The entrance examination revealed a Grade II retinopathy. The tongue was very dry, and the teeth were few in number and in poor repair. The neck was supple; the thyroid was not enlarged. The chest was enlarged in the anteroposterior diameter. There was bronchovesicular breathing throughout, and there were coarse rales in the right base. Generalized emphysema was noted. The heart did not appear enlarged. The heart sounds were distant; there was a normal sinus rhythm, and no murmurs were audible.

The abdomen was moderately distended. The liver was 5 to 6 cm. below the right costal margin. There was a large, hard, slightly tender mass, about 10 by 15 cm., in the para-umbilical and lower abdomen; and there was slightly more presentation of this mass in the left lower quadrant than in the right. A definite outline of the mass could not be ascertained with certainty. On further examination it was felt that this abdominal mass was pulsating, and on auscultation a soft bruit could be heard over the area.

The rectal examination was essentially within normal limits. There was a mild prostatic hypertrophy. The neurological examination was not remarkable. No enlarged generalized lymph nodes were seen.

* From the University Hospitals and University of Wisconsin Medical School.

*Laboratory Studies:* The following findings were revealed: On admission the hemoglobin was 12, and the prothrombin time was 100. There was no urinalysis report available. The day following admission, February 27, 1954, the hemoglobin was 10.6; and the white blood cell count was 18,800, with 77 per cent polymorphonuclear cells, 14 per cent lymphocytes, and 9 per cent monocytes. During this day the fasting blood sugar was 141 mg. per cent; and the nonprotein nitrogen was 52 mg. per cent, with a 3.6 creatinine. The Wassermann test was negative. On March 1, the sodium was 147 mEq. per liter, and the chlorides were 99 mEq. per liter.

*Course:* During the patient's hospitalization he was treated conservatively and given supportive therapy. He was maintained on intravenous fluids, and it was the clinical impression that the abdominal mass was getting progessively larger. At 11:35 p.m. on February 28, the second hospital day, the patient became very confused and dyspneic and showed considerable pallor. His abdomen became even more distended and was expanding rapidly. The umbilicus became everted. There was no true shifting dullness or fluid wave palpable. The supportive therapy was continued during this time. On March 1, the following day, a Foley catheter was inserted and 100 cc. of dark urine collected. However, at 9:30 p.m. that same day the patient expired.

### Clinical Discussion

The case to be reviewed will illustrate a complication of a common, yet very controversial, disease in so far as its pathogenesis is concerned. Doctor Young will discuss the clinical aspects of this case.

**Dr. W. Young:** In an 83-year-old man I am alerted to the likelihood of degenerative diseases. The report tells us that he had had frequent episodes of vomiting for 8 to 10 years. Also, it states that there had been some recent weight loss; and in the physical examination the patient is described as being fairly well nourished. The fact that he had been vomiting over such an extended period without any marked nutritional disturbance would tend to indicate that the vomiting was functional rather than organic. The vomiting and abdominal distress occurred after eating in excess or drinking large quantities of cold water, which might indicate that the patient's eating habits were faulty. With a history of increasing constipation over a two-year period, carcinoma of the bowel should be considered until disproved; however, there are many other causes of constipation. Two nights prior to admission the patient had had another episode of vomiting, and we are told that after considerable vomiting he had coffee-ground emesis. Coffee-ground emesis usually indicates that blood has been acted on by gastric acid. The straining and retching of vomiting may have traumatized the stomach so that there had been bleeding. We are not told that there were any clots or fresh blood vomited. The nocturia of two times per night would bring the prostate and the kidneys under suspicion. Degenerative changes in the kidneys might have resulted in loss of ability of concentration.

The physical examination reports that the patient was confused. This may well have been from his illness or from cerebral arteriosclerosis. The presence of Grade II retinopathy might support in part the possibility of cerebral sclerosis. The rather normal temperature and pulse might be a reflection of the aged patient's inability to react rather than an indication of absence of an acute process. The dry tongue almost certainly points to dehydration, but the patient's electrolytes were not badly disturbed. The coarse rales at the right base suggest bronchiectasis or bronchial pneumonia. Old people frequently aspirate vomitus resulting in a bronchial pneumonia type of pneumonitis. The slightly distended abdomen is not significant in itself. The liver being palpable 5 to 6 cm. below the costal margin might be due to pulmonary emphysema rather than liver disease, but this is purely speculation. The presence of the hard abdominal mass which was believed to pulsate and over which a soft bruit could be heard suggests an abdominal aneurysm. The aneurysm apparently was not a saccular one as it was not discretely outlined, and later we are told that it increased rapidly in size. The rapid increase in size would suggest that the palpable mass represented bleeding from a rupture of the aorta rather than an aneurysm. The drop in hemoglobin and the pallor support the possibility of bleeding. The slight increase in blood sugar and nonprotein nitrogen may have been due to the dehydration.

My diagnosis, therefore, is spontaneous rupture of an abdominal aorta into the retroperitoneal space, either at the site of a pre-existing aneurysm or atheromatous thinning. Spontaneous rupture of the abdominal aorta is much more frequent in the male than in the female. Such a rupture is usually into the retroperitoneal space but occasionally takes place into free peritoneal cavity. If a patient survives the initial shock of the rupture, he will frequently live for a matter of hours or for two or more days. Missing from the typical picture of rupture of the aorta is the excruciating pain in the abdomen or back. The pain is believed due to blood tearing through retroperitoneal tissues. This man was described as having had "some mid-abdominal pain," but nothing was said about severe pain.

If I may, I would like to see the x-rays at this time. If my diagnosis is correct, the x-rays might show a mass in the midportion of the abdomen or a loss of psoas outline. If there was a pre-existing aneurysm of the abdominal aorta, there might be a chalk outline of the dilated aorta.

**Dr. M. Winston.** There were two sets of abdominal films taken on the day the patient entered the hospital. There is evidence of calcareous linear density extending down along the right abdomen starting at the first lumbar vertebra. Other calcareous shadows extend upward along the left medial abdomen, seemingly arising from approximately the fifth lumbar. There is a suggestion of a soft tissue density, measuring 8 to 10 cm. in diameter, lying in the midabdomen. This has the appearance of a large abdominal aneurysm. Little appreciable change in size is noted on subsequent films. It is quite well visualized in the lateral view. The wall is apparently 2 to 3 cm. thick, as estimated by the soft tissue density.

*Conclusions:* There is evidence of a large abdominal aneurysm, and there is marked arteriosclerosis of the pelvic vessels. There may possibly be another smaller aneurysm in one of the pelvic arteries, where another rounded calcareous shadow 4 cm. in diameter is visualized. This probably arises from one of the bifurcating arteries or possibly just before the bifurcation.

**Doctor Young:** I will stay with my diagnosis of spontaneous rupture of the abdominal aorta. This is not a common occurrence; but on the other hand, it is not rare and can be expected to be seen more frequently with the increasing number of geriatric patients.

### Necropsy Findings

(University Hospitals 54:66)

**Don W. Churchill:** At autopsy, external inspection of the body revealed no abnormalities other than slight obesity and a yellow discoloration over the dorsum of the hands and fingers. Further examination revealed generalized arteriosclerosis which produced extreme narrowing of the coronary arteries, a severe arterial nephrosclerosis, and a large fusiform aneurysm involving the distal portion of the abdominal aorta (Fig. 1). This aneurysm measures 15.5 by 11.0 cm. in its greatest dimensions. Numerous large and small thrombi were present in the aneurysm. The media of the aorta had been split into two layers in many places. The aortic wall was frequently less than 1 mm. in thickness;

Figure 1.

it was extremely friable. Anteriorly, at the level of the third lumbar vertebra, there was a small medial rupture where the aortic wall had given way. The remainder of the aorta contained numerous atheromatous and calcific plaques. It was estimated that 30 to 50 per cent of the intimal surface above the aneurysm was involved in this way. Surrounding the aneurysm and extending to the retroperitoneal portions of the abdominal cavity, but concentrated primarily on the left side, was a large hematoma which had dissected the parietal peritoneum from the somata. The hemorrhage had formed currant jelly-like clots, many of which were mixed with interstitial tissue. The infiltrating blood extended laterally into the ascending and descending mesocolon and superiorly into the pancreas. Only 200 cc. of free or clotted blood was present in the coelom. No erosion of the vertebral bodies had occurred. The inferior vena cava had been displaced several centimeters to the right, but there was no evidence of interference with the venous blood flow. No gross blood was present in the gastrointestinal tract which would account for the hematemesis.

Microscopic studies showed the medial elastic and collagenic components of the aorta to be fragmented, reduced in number, and hyalinized. Large atherosclerotic plaques containing calcium were loosely attached to the subintima. Diffuse, ischemic, degenerative changes were also noted in the myocardium, although no infarction was present. The arterial nephrosclerosis was confirmed by the presence of wedge-shaped areas of fibrosis in the renal cortex. Sections of the pancreas showed extensive interlobular hemorrhage. There was a diffuse pneumonitis with a rather severe bronchiolitis due to the terminal aspiration of bile.

It appears from the structure of the wall of the aortic aneurysm and the distribution of blood in the retroperitoneal space that the aneurysmal rupture resulted in a continuous and gradual loss of blood.

**Dr. J. J. Lalich:** Aneurysmal dilatation is a complication of atherosclerosis. Fortunately, the atherosclerotic aneurysms are much less frequent than the atherosclerosis. Maniglia and Gregory reported on the increasing incidence of arteriorsclerotic aneurysms in the *Archives of Pathology,* Volume 54, page 298. These authors analyzed over 58,000 reported cases in the literature and added 6,000 of their own. They observed that since 1906 the incidence of syphilitic aneurysms has been decreasing, whereas the percentage of arteriosclerotic aneurysms has been rising. Arteriosclerotic aneurysms, which occur principally in the abdominal aorta, have become more numerous in recent years than the syphilitic aneurysms. In their series of cases these authors observed that syphilis initiated 58 and arteriosclerosis 6 of the thoracic aortic aneurysms. In contrast to this, in the abdominal aorta syphilis produced only 1 of the 30 aneurysms.

Doctor Hass, who recently discussed arterial disease before the Society of Wisconsin Pathologists, recommended that the term arteriosclerosis be limited to the proliferative response, such as intimal fibrosis. Atherosclerosis, on the other hand, should be restricted to those cases exhibiting both degeneration and lipid infiltration of the intima and media. The case presented today is an example of atherosclerosis. The deterioration and fragmentation of the elastic fibers and hyaline degeneration of the collagenic fibers in the media predisposed to the dilatation and perforation of the abdominal aorta.

In conclusion, one can add that pathologists observe small atherosclerotic abdominal aneurysms at autopsy in patients who have died for other reasons, which suggests that this complication is not uncommon.

**Dr. E. R. Schmitt:** This case represents the end pathology as was seen by Virchow many years ago. I am wondering how effective we are in diagnosing lesser lesions, especially the dynamic, painful, abdominal aorta which is seen every now and then. With the pressure from this aneurysm one would expect to find some erosion of the vertebra or symptoms of pain in the back, and the patient had neither of these. In view of his age and the rapid progression of his symptoms, there was little that could be done except to give symptomatic treatment.

# Present Status of Fluoridation in Wisconsin

## As It Looks to Your State Board of Health

SINCE Sheboygan began the fluoridation of its public water supply in 1946, there has been a steady increase in the number of Wisconsin communities that have adopted this important dental public health measure. At the present time there are 98 Wisconsin public water supplies being fluoridated. These public water supplies serve 125 Wisconsin communities with a total population of over 1,600,000 people.

Nationally, there are over 1,000 communities that have mechanically fluoridated public water supplies, serving a total of over 20,000,000 people. Another 3,500,000 people in the United States consume a public water supply that is naturally fluoridated.

The early fluoridation demonstration programs as set up at Sheboygan, Wisconsin; Grand Rapids, Michigan; Newburgh, New York; Marshall, Texas; Brantford, Ontario, Canada; and Evanston, Illinois, have now been in successful operation for several years. The dental caries attack rates in these communities have been greatly reduced. For example, at Sheboygan, following seven years of fluoridation, the caries attack rate in kindergarten children (5–6 years) has been reduced 62 per cent; in the fourth grade children (9–10 years) it has been reduced 42 per cent; and in the seventh, eighth, and ninth grade children (12–13–14 years) the caries reduction has been 37 per cent. Similar reductions in dental decay have been reported from all communities which have been fluoridating for a like period of time. We know that it will take another seven years to show the full benefit in the 14-year age group; then a 65 per cent reduction is anticipated.

The fluoridation of public water supplies has already proved to be one of the great public health measures of all time. However, all public health programs apparently must undergo a lengthy period of rather violent opposition before they are given universal approval. The same opposition that was engendered against such public health measures as immunization, chlorination, pasteurization, etc., is now being directed at the fluoridation program. When fluoridation programs were first started, the opposition used the argument that there was no proof that fluoridation would reduce the incidence of dental decay. Now that fluoridation has been in operation long enough to prove that it does reduce the incidence of dental decay, the opposition claims that it causes all sorts of acute and chronic illness. They are quite outspoken in their claims that physicians, dentists, and research workers are guilty of misrepresentation when they state that one part per million of fluoride in the communal water supply is perfectly safe for all human beings to consume.

The opposition claims that such national health organizations as the American Medical Association, American Dental Association, U. S. Public Health Service, American Public Health Association, National Research Council, etc., approved fluoridation without having made any investigations on the subject. They even insinuate that these organizations are deliberately attempting to poison the public, that they are part of a communistic conspiracy to overthrow our government, and that the opponents of fluoridation are the true guardians of the health of the public.

The opposition not only challenges fluoridation but also seeks to prevent chlorination of our public water supplies.

It certainly is a serious matter when the scientific judgment and integrity of the health professions are challenged in public health matters by people who are untrained in the health sciences, who have no responsibility for the health of the people, and who base their arguments and conclusions on completely unscientific data. Undoubtedly, some of the arguments against fluoridation are made in good faith; but most of them are based on hearsay, conjecture, suspicion, emotionalism, and misinterpretation of the scientific literature.

While the opponents of fluoridation have been successful in a few communities in creating enough fear or doubt in the minds of the people to defeat the fluoridation program temporarily, an ever-increasing number of communities in both our state and the

nation are adopting the program. Philadelphia started to fluoridate its public water supply serving 2,000,000 people the first of October, and Chicago is scheduled to start fluoridation the first of January.

If we are to combat the opposition to fluoridation effectively, the health professions must carry on a continuous educational program to acquaint the public with the true, scientific facts relative to fluoridation. Any thing that delays the adoption of this safe, effective, and economical dental public health measure serves only to penalize the children of today and the adults of tomorrow.—FRANCIS A. BULL, D.D.S., M. S. P. H., *Director, Dental Health Division.*

## SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

On April 1, 1954, the March of Medicine began its ninth consecutive year of radio broadcasting. The programs, which are tape recorded, feature Dr. R. C. Parkin, discussing various health problems with a lay person who is called "Your Medical Reporter." At present 40 stations in Wisconsin, one in Michigan, and one in Minnesota are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

| *Station* | *City* | *Time* | |
|---|---|---|---|
| WATK | Antigo | Saturday | 8:45 a.m. |
| WHBY | Appleton | Saturday | 8:30 a.m. |
| WATW | Ashland | Saturday | 8:15 a.m. |
| WHSA | Brule | Saturday | 1:15 p.m. |
| WHKW | Chilton | Saturday | 1:15 p.m. |
| WCHF | Chippewa Falls | Saturday | 9:00 a.m. |
| WHWC | Colfax | Saturday | 1:15 p.m. |
| WHAD | Delafield | Saturday | 1:15 p.m. |
| WEAU | Eau Claire | Saturday | 11:45 a.m. |
| KFIZ | Fond du Lac | Saturday | 5:30 p.m. |
| WBAY | Green Bay | Saturday | 3:15 p.m. |
| WHHI | Highland | Saturday | 1:15 p.m. |
| WJMS | Ironwood, Michigan | Saturday | 8:15 a m. |
| WLIP | Kenosha | Saturday | 11:15 a.m. |
| WKBH | La Crosse | Saturday | 11:00 a.m. |
| WLDY | Ladysmith | Saturday | 9:30 a.m. |
| WHA | Madison | Saturday | 1:15 p.m. |
| WIBA | Madison | Saturday | 9:00 a.m. |
| WOMT | Manitowoc | Saturday | 9:15 a.m. |
| WMAM | Marinette | Saturday | 11:45 a.m. |
| WDLB | Marshfield | Saturday | 10:45 a.m. |
| WIGM | Medford | Saturday | 10:15 a.m. |
| WEKZ | Monroe | Friday | 2:00 p.m. |
| WPFP | Park Falls | Saturday | 10:45 a.m. |
| WIBU | Poynette | Thursday | 2:45 p.m. |
| WPRE | Prairie du Chien | Saturday | 10:15 a.m. |
| WRJN | Racine | Sunday | 5:45 p.m. |
| KAAA | Red Wing, Minnesota | Monday | 9:15 a.m. |
| WRDB | Reedsburg | Tuesday | 9:30 a m. |
| WOBT | Rhinelander | Saturday | 10:30 a.m. |
| WHRM | Rib Mountain | Saturday | 1:15 p.m. |
| WJMC | Rice Lake | Saturday | 9:45 a.m. |
| WRCO | Richland Center | Wednesday | 3:30 p.m. |
| WTCH | Shawano | Sunday | 6:45 p.m. |
| WHBL | Sheboygan | Tuesday | 7:15 p.m. |
| WLBL | Stevens Point | Saturday | 1:15 p.m. |
| WDOR | Sturgeon Bay | Thursday | 9:15 a.m |
| WDSM | Superior | Sunday | 9:00 p.m. |
| WTTN | Watertown | Tuesday | 11:30 a.m. |
| WSAU | Wausau | Saturday | 9:15 a.m. |
| WBKV | West Bend | Saturday | 11:30 a.m. |
| WHLA | West Salem | Saturday | 1:15 p.m. |

# . . . . THE PRESIDENT'S PAGE . . . .

FOR many years I have lived on the banks of the Fox River and, in the summertime, on the shore of beautiful Green Bay, into which the historic river flows. On many an evening I have stood on the sandy beach, where my children and grandchildren have played, and peered through the haze that hung over the water. I have seen the shadowy birchbark canoes glide silently by, and I have strained my ears that I might hear the guttural voices of the Winnebagos as they stealthily planned a surprise attack on their ancient enemies, the Menominees.

What a pageant of history has passed my door! What a galaxy of stars has played on the historical stage in the events of three centuries that unfold themselves before me. Nicolet was the first white man to come to these shores; then came the brave Jesuit missionaries. They were followed by the coureurs de bois, the voyageurs, and fur traders. There was Charles de Langlade, who left La Baye Verte leading a large body of Indians who, with the French, accomplished Braddock's defeat at the Monongahela.

The soldiers came. At the mouth of our river, three nations built forts, over which flew the tri-color of France, the Union Jack of Great Britain, and our own Stars and Stripes. The surgeon's quarters of old Fort Howard still stand. There Beaumont lived and worked. There Zachary Taylor, who later became the President of the United States, was once stationed as a young army officer. Eleazer Williams lived in the old agency house at Deutchman's Creek, and thousands of my fellow citizens firmly believe he was the Lost Dauphin of France.

In my home city there is the museum that eloquently exhibits the flow of history through Wisconsin's gateway with its Indian relics and old Colonial costumes. There is the Tank Cottage, the Cotton House, the memorial marking the spot where stood Wisconsin's first courthouse. I have dreamed that some day a shrine of medicine would be erected on this historic ground. But one day last summer I went to attend a meeting on prepaid plans at Prairie du Chien. I started out along that waterway of history that led from Fort Howard to Fort Crawford. My automobile was my canoe. I ascended the rapids at De Pere; I paddled across the lake of the Winnebagos. I pushed up the upper river past its junction with the Wolf, where tribes of Sacs and Foxes used to roam. I journeyed to the marshy headwaters, crossed the old portage, and traveled down the Wisconsin River to its mouth.

There I stood on the site of old Fort Crawford, where Doctor Beaumont did his monumental work. A great feeling of reverence came over me. I looked out at the Father of Waters there before me and at the beautiful hills across the river glistening in an early morning rain. Then I knew that this was the place for our shrine of medicine.

Wisconsin has produced great doctors throughout all its history. Thousands of them lived and died and perhaps were little known beyond the towns and hamlets in which they worked. We have interesting exhibits of these men to show. Wisconsin doctors of the present and the future are making and will continue to make medical history.

To preserve for posterity the accomplishments of Wisconsin's men of medicine, we propose to build a shrine on the site of old Fort Crawford. We have created a Section on Medical History to accomplish this, and one day in the not too distant future we will have a place in which the work of Wisconsin doctors can be exhibited. Every school child, every housewife, every father and mother, every Wisconsin citizen will be able to see the past, present, and future of Wisconsin medicine.

With an opportunity like this one before us, the medical profession can do no less than give every support through membership in the Section on Medical History. Your annual dues of $5 in this section will do much to preserve Wisconsin's fine medical heritage.

Arthur J. McCary M.D.

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# Transactions of the 1954 Regular Session, House of Delegates, State Medical Society of Wisconsin

## FIRST SESSION

### Monday, October 4, 1954

The opening session of the House of Delegates of the State Medical Society of Wisconsin, held at the Schroeder Hotel, Milwaukee, convened at 9:20 a.m., Dr. L. O. Simenstad, Speaker of the House, presiding. A moment of silent prayer was observed.

## Report of Committee on Credentials

The Committee on Credentials was composed of Drs. J. W. Fons, chairman, Milwaukee; P. H. Gutzler, River Falls; and M. V. Overman, Neillsville. Dr. T. J. Aylward of Milwaukee, who had previously been appointed as chairman, was unable to be present because of injuries suffered in an automobile accident.

The committee verified the registration of 49 delegates and 10 alternate delegates entitled to vote at this session of the House of Delegates. In addition, seven alternate delegates, three councilors, and five officers registered their attendance.

On motion of Doctor Fons, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll totaling 59 was accepted as the official roll of this session of the House, to stand for the entire session.

## Announcement of Reference Committee Appointments

Speaker Simenstad announced the following appointments to reference committees:

*Reference Committee on Reports of Officers:* Drs. S. A. Morton, Milwaukee, chairman; W. D. Stovall, Jr., Brodhead; H. J. Kief, Fond du Lac; E. W. Humke, Chilton; and R. A. Thayer, Beloit.

*Reference Committee on Reports of Standing Committees:* Drs. G. W. Carlson, Appleton, chairman; E. C. Cary, Reedsville; C. W. Stoops, Jr., Madison; C. A. H. Fortier, Milwaukee; and K. L. Bauman, Lancaster.

*Reference Committee on Resolutions and Amendments to the Constitution and By-Laws:* Drs. T. W. Tormey, Jr., Madison, chairman; J. A. Enright, Milwaukee; H. A. Aageson, Oconto; W. C. Henske, Chippewa Falls; E. D. Sorenson, Elkhorn; and J. D. Leahy, Park Falls.

## Minutes of the 1953 Session Approved

On motion of Dr. D. N. Goldstein, Kenosha, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, minutes of the 1953 regular session of the House of Delegates, as printed in the December 1953 issue of *The Wisconsin Medical Journal,* were approved.

## Standing Rules Adopted

On motion of Dr. R. L. MacCornack, Sr., Whitehall, seconded by Dr. E. W. Humke, Chilton, carried, standing rules as adopted in previous sessions were adopted for this session of the House.

## Reports of Officers

The following report of the Council was printed in the *Handbook for Delegates:*

## REPORT OF THE COUNCIL

R. G. Arveson, chairman.

Under the Constitution and By-Laws of the Society the Council serves in effect as a board of trustees, and many of its activities are concerned with management details and carrying out policy decisions made by the House of Delegates. Because minutes of Council meetings are printed in considerable detail in *The Wisconsin Medical Journal,* it seems repetitious to do other than emphasize matters which require House of Delegates action and further consideration.

### Implementation of Programs

A major problem before the Council is implementation of various programs which have received approval of the House of Delegates. The Audit and Budget Committee of the Council, working with the secretary and the treasurer, submits detailed recommendations for the year, following action by the House in establishing dues. It might be emphasized to the House that the conduct of public health conferences and various special scientific endeavors is time-consuming and necessarily involves a considerable amount of expense. The teaching clinics, industrial clinics, and school health conferences have met with marked success and doubtless should be continued; but the Council is in agreement that in authorizing new projects the House must give attention to their impact upon the budget of the Society. The budget is reported in detail following the annual meeting of the Council, and thus the financial structure of the Society is reported to the entire membership annually.

In this connection the Council reports that Wisconsin will be the host state for the 1955 National Rural Health Conference, and, if practical, meetings of certain of the State Medical Society's committees will be scheduled to coincide with the National Conference to assure adequate representation and to assist in permitting Wisconsin to have close contact with this significant event.

### The March of Medicine

Another matter has to do with the development of a television program in the state. Several groups have been concerned with this matter, and the March of Medicine—Television will be available on a public service basis late in 1955. The program format will be limited to situations typical of the average practitioner and will be strictly limited in respect to description of treatment. Prior to production all programs will be approved by the State Medical Society. In the distribution of what is known technically as a "kinescope" the Society will obtain approval from the county medical society in the county in which the station is located. In fashion similar to the March of Medicine—Radio, all correspondence resulting from television programs will be routed through the Society so that a consistent pattern will be followed in its handling.

Still another interesting public health project is one which has met with such success that all concerned with it are somewhat puzzled as to carrying it out. The tape recordings provided for the March of Medicine—Radio have been studied and a number of them duplicated for loan to high schools in Wisconsin in connection with certain of their courses. An accompanying description of the tape is mimeographed, and any technical words used in the broadcast are defined. Further material with reference to that project will be reported from other sources. The delegates should consider it a matter of prime concern.

Other matters will come before the House on direct report from committees more closely associated with the projects, and several resolutions, reported on this page and on pages 639 and 640, are self-explanatory.

### Standing Rules Proposed

In addition to those resolutions, the House of Delegates should consider, in the opinion of the Council, the acceptance of several additional standing rules for the conduct of its sessions:

(1) Credentials for the purpose of registration of voting delegates should be distributed direct to the delegate from the state headquarters. Present procedure routes these credentials through the county secretary, and past experience indicates that many delegates come to the Annual Meeting without the necessary credentials for registration. This causes delay and confusion.

(2) The registration of those in attendance at the House of Delegates, other than as voting delegates, should be handled at a separate registration table.

(3) The credentials committee should be seated at the registration table to handle any problem that may arise, and in particular, the matter of seating an alternate at a session when the delegate himself cannot be present.

## REPORT ON NECROLOGY

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated by boldface type.

**M. J. Ansfield**
_____Milwaukee
T. W. Ashley__Kenosha
**R. J. Bach___Milwaukee**
L. H. Baldwin___Gillett
**E. C. Barnes_____Ripon**
**L. W. Beebe___Superior**
**A. E. Belitz_____Pepin**
A. L. Breed
____Des Moines, Iowa
**W. F. Cowan**
_____Stevens Point
S. W. Doolittle
_____Lancaster
**F. A. Douglas**
_____La Crosse
**R. M. Fellows**
_____Milwaukee
**W. E. L. Froggatt**
_____Cross Plains
**I. V. Grannis_Menomonie**
**J. H. Hardgrove**
_____Shawano
R. C. Hartman
_____Alamo, Texas
**H. P. Haushalter**
_____Milwaukee
**S. G. Higgins Milwaukee**
**M. Q. Howard**
Ft. Steilacoom, Wash.
**E. Jackson___Milwaukee**
**J. A. Jackson___Wausau**
**T. L. Jacobson__Delavan**
**A. W. Jones___Randolph**
P. P. M. Jorgensen
_____Kenosha
**E. E. Kidder**
_____Stevens Point
W. E. Kiley__Milwaukee
C. R. Kossat__Milwaukee
O. E. Lademan
_____Milwaukee
F. B. Mead
__Riverside, California
**W. E. Meanwell_Madison**
C. H. Meyst__Milwaukee
**A. L. Millard_Marshfield**
**J. A. Mudroch_Columbus**
**R. A. Mullen**
_____Tampa, Florida
E. R. Murphy_Stratford
A. C. Nieman
_____Wauwatosa
**W. M. Nesbit___Madison**
**T. W. Nuzum_Janesville**
**Orvil O'Neal_____Ripon**
**H. S. Roby___Milwaukee**
**A. M. Rosenheimer**
_____Beaver Dam
W. D. Sanderson
____Ft. Campbell, Ky.
J. J. Scott_____Durand
**D. R. Searle**
Safety Harbor, Florida
**F. A. Stratton**
_____Milwaukee
**A. F. Stueck_Manitowoc**
C. N. Stuesser_Hartford
E. F. Swarthout
Jensen's Beach, Florida
**E. H. Townsend**
_____La Crosse
**G. F. Treadwell**
_____Friendship
**J. C. Tyvand__Whitehall**
C. C. Urquhart__Hurley
**R. E. Van Schaik_Marion**
**L. A. Weisfeldt**
_____Milwaukee
**C. A. Wright__Wautoma**

The following resolutions, offered by the Council, were published in the *Handbook for Delegates:*

### UNIFORM EXPIRATION DATE, DELEGATE TERM

WHEREAS, The House of Delegates is the legislative body of the Society and possesses important responsibilities in determining policies of the Society, and

WHEREAS, Each delegate is elected by the component county society which he represents and for such term as is determined by the constitution and by-laws of such society, and

WHEREAS, Component county medical societies do not follow a uniform pattern in this respect, so that terms of delegates expire at varying times during the year, and

WHEREAS, This results in inability to keep delegates fully informed of various matters and even causes difficulty in ascertaining the actual list of delegates at any given time, and

WHEREAS, In recognition of a similar problem the American Medical Association found it advisable to prescribe that in the election of delegates, state medical associations must elect so that terms expire at the end of a calendar year,

THEREFORE, BE IT RESOLVED, That Chapter XI, Section 8, of the By-Laws be amended to read as follows:

> Sec. 8. (At some meeting in advance of the annual session of this Society,) each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. **The term of office shall be pursuant to the constitution and by-laws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate.** The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least 30 days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

(Note: material to be deleted indicated by parentheses, new material in bold face.)

### LENGTH OF RESIDENT MEMBERSHIP

WHEREAS, Provision exists in the By-Laws, Chapter XI, Section 3, last paragraph, whereby special membership may be granted those in residency training for a period of three years, and

WHEREAS, Residency training is, in some cases, extended on a five-year basis,

THEREFORE, BE IT RESOLVED, That such provision be amended by striking the word "three" and inserting in lieu thereof the word "five."

### NEW DATE FOR DETERMINING DELEGATE APPORTIONMENT

WHEREAS, Chapter III, Section 2, of the By-Laws provides a formula under which is determined the number of delegates to which each component county society is entitled, and

WHEREAS, This is the number of fully paid members as of a date 30 days in advance of the first session of the House of Delegates at the Annual Meeting, and

WHEREAS, With the change in time of the Annual Meeting from early fall to early spring, it appears that such provision would cause confusion and difficulty,

THEREFORE, BE IT RESOLVED, That Chapter III, Section 2, third paragraph, be amended so as to strike the phrase "a date thirty days in advance of," and insert in lieu thereof "the close of the calendar year preceding."

### ANNUAL MEETING OF COUNCIL

WHEREAS, Chapter VI, Section 1, of the By-Laws, relating to meetings of the Council, provides that the annual meeting of the Council shall be held in February of each year, and

WHEREAS, The next Annual Meeting of the Society is scheduled in early May of 1955 and, consequently, the time of the annual meeting of the Council should be rearranged,

THEREFORE, BE IT RESOLVED, That Chapter VI, Section 1, of the By-Laws, be amended by striking from the second sentence the words "during February."

## Resolutions Introduced By the Council By Request But Without Recommendation

### SECTION ON UROLOGY

WHEREAS, There is a great and growing interest in the field of urology among physicians in general, and

WHEREAS, There is a large and increasing group of physicians specializing in urology as evidenced by a roster of 59 members in the Wisconsin Urological Society, and

WHEREAS, The specialty of urology has no official representation within the structure of the State Medical Society of Wisconsin, and

WHEREAS, Establishment of a Section on Urology in the State Medical Society would stimulate further interest in urology by scientific meetings in connection with Annual Meetings of the State Medical Society of Wisconsin, and

WHEREAS, Membership in such a section would be limited to those who limit 75 per cent of their practice to the practice of urology, and

WHEREAS, The Milwaukee Urological Society and the Wisconsin Urological Society have each given their unanimous approval,

THEREFORE, BE IT RESOLVED, That a Section on Urology be established in the State Medical Society of Wisconsin.

### SECTION ON PUBLIC HEALTH

WHEREAS, The Wisconsin Society of Public Health Physicians numbers 20 physicians in full-time practice of the specialty of public health, who are members of their county and state medical societies, and

WHEREAS, It is the feeling of that Society that there would be better rapport and understanding between other physicians and those in public health through closer contact with the business affairs of the parent body by representation in the House of Delegates, and,

WHEREAS, There would be closer contact with other interests and support of those interests of the parent body, and

WHEREAS, The Wisconsin Society of Public Health Physicians believes all elements of the medical profession will gain in public esteem by drawing together,

NOW, THEREFORE, BE IT RESOLVED, That the Wisconsin Society of Public Health Physicians apply for section status in the State Medical Society, and if a Section on Public Health is authorized, it have the same voting and other privileges as other sections.

The following resolutions and statement were presented as a supplementary report of the Council:

## FUTURE ANNUAL MEETINGS

The general Council of the State Medical Society feels that the planning of the Council on Scientific Work for the 1955 Annual Meeting, which will be held on Tuesday, Wednesday, and Thursday, May 3, 4, and 5, should be formally reported to the House of Delegates.

There is no change in the planning as to two days of the meeting; but on the second day, Wednesday, May 4, the entire morning session would be devoted to a series of 15-minute presentations by nationally known individuals who would review recent developments in selected fields under a "What's New" program in surgery, in internal medicine, in pediatrics, in anesthesiology, in pharmacology, in radiology, in orthopedics, and in obstetrics and gynecology.

During the afternoon specially organized groups of physicians will be asked to organize their own program and official meetings.

The Council on Scientific Work has been in communication with the Wisconsin Surgical Society, the Wisconsin Society of Anesthesiologists, the Wisconsin Orthopedic Society, the Wisconsin Society of Obstetrics and Gynecology, the Wisconsin Radiologic Society, the Wisconsin Academy of General Practice, and the Wisconsin Chapter of the American Academy of Pediatrics. The afternoon program would feature an outstanding out-of-state guest, who would also participate in the morning program, and several state speakers. The various groups participating in this type of program would conclude with separate dinners for their members and guest speakers.

Physical arrangements, including reservations for the dinner functions, would be coordinated by the staff of the State Medical Society. Expense of all out-of-state speakers will be carried through the funds of the State Society.

This development is intended to be, in part, a contribution to the solution of "too many" medical meetings; to provide an answer to those that have expressed strong interest in having a specially designed program for their particular group during the course of the Annual Meeting; and to further strengthen attendance and interest in the Annual Meeting, which is an important function to the whole of medicine.

## RESOLUTION ON NURSING EDUCATION

WHEREAS, The 13,771 nurses in Wisconsin play a vital role in the health care of the people of this state; and

WHEREAS, The medical profession is deeply conscious of a critical need for all types of nursing personnel to assure adequate patient care in hospitals, specialized institutions, and the home; and

WHEREAS, The Woman's Auxiliary to the State Medical Society of Wisconsin had made valiant and successful efforts at nurse recruitment, supplying literature, personnel, and scholarship funds; and

WHEREAS, Several special committees of the State Medical Society functioning over a period of years have concluded that the major problems of nursing education will require joint consideration by the medical and nursing professions, leading educators, and several agencies of state government and the public;

NOW, THEREFORE, BE IT RESOLVED, By this House of Delegates of the State Medical Society of Wisconsin that the nurses of this state be paid high tribute during National Nurse Week, October 11–16, 1954, and that the Wisconsin State Department of Nurses and the Wisconsin State Nurses Association be commended for their efforts to expand and develop the nursing profession in the state;

AND BE IT FURTHER RESOLVED, That the State Medical Society of Wisconsin offer its full cooperation with services, facilities, and advice for an immediate joint effort to further improve the education and distribution of nurses in Wisconsin;

AND BE IT FURTHER RESOLVED, That a copy of this resolution be transmitted to the Woman's Auxiliary that it may record in its records the appreciation of the State Medical Society for its work in this field.

## RESOLUTION ON HIGHWAY SAFETY

WHEREAS, Deaths and injuries from highway accidents have reached such frightening proportions as to threaten to offset the achievements of medicine and public health in the conquest of illness and diseases during the past half century; and

WHEREAS, The tremendous financial and production losses and the great personal tragedies for victims and relatives occasioned by highway accidents are compounded by the increasingly burdensome diversion of medical and hospital personnel and facilities for the care of needlessly injured persons; and

WHEREAS, The Governor's Conference on Highway Safety in Milwaukee on October 1, 1954, was a highly encouraging appraisal of the magnitude of the problem and the necessity for more definitive action; and

WHEREAS, The prevention of highway accidents is not the sole responsibility of the police, the highway engineer, or the medical profession but most certainly requires the development of a conscious public "will to live safely" on the highway;

NOW, THEREFORE, BE IT RESOLVED, That this House of Delegates commend highly those responsible for the planning of the recent conference and express the hope that this conference on highway safety become an annual event;

AND BE IT FURTHER RESOLVED, That the State Medical Society of Wisconsin offer its full cooperation and assistance in the development of future conferences and those programs which hold promise for greater highway safety.

## RESOLUTION ON *TODAY'S HEALTH*

WHEREAS, The American Medical Association publication, *Today's Health*, is the finest publication of its kind in the nation; and

WHEREAS, Widespread circulation of *Today's Health* offers an unparalleled opportunity for public education in health care, family financial planning

for health, and the activities of American medicine for health improvement; and

WHEREAS, The Woman's Auxiliary to the State Medical Society of Wisconsin has as one of its major projects a campaign to place *Today's Health* in every physician's office and in schools and public libraries, as well as in private homes;

NOW, THEREFORE, BE IT RESOLVED, By this House of Delegates that the Woman's Auxiliary to the State Medical Society of Wisconsin be commended for its outstanding contribution to public health through the promotion of this magazine;

AND BE IT FURTHER RESOLVED, That this House of Delegates request each member of the State Medical Society of Wisconsin to give every encouragement, cooperation, and support to the Auxiliary's subscription campaign for *Today's Health.*

## STUDENT LOAN FUND

At the request of the chairman of the Council, Dr. R. G. Arveson, Secretary Crownhart reported that contributions to the Student Loan Fund as of September 21, 1954, were $14,805. Loans had been made to the extent of $6,550.

Mr. Crownhart also reported that the Wisconsin Surgical Society had contributed $1,000 to the Student Loan Fund since September 21. A communication received from a physician who recently entered the practice of medicine stated that his medical education had been financed by a practicing physician, but not on a loan basis. The young physician wished to perpetuate the generosity of his benefactor and had pledged to the Student Loan Fund regular periodic payments to the total of approximately $3,000.

## SCIENTIFIC, EDUCATIONAL, AND CHARITABLE FOUNDATION

The following statement of the Council proposing the creation of a scientific, educational, and charitable foundation of the State Medical Society was published in the *Handbook for Delegates:*

For some time the State Medical Society has been aware that a number of its members, as well as friends of medicine outside its ranks, were, or could be, interested in making grants or contributions of various types to projects which naturally fall within the province of the medical profession.

About three years ago the Society established a trust called the Student Loan Fund which was designed to acquire funds to be administered as loans to needy medical students. This was a tangible effort of the medical profession in this state to solve an important problem through a closely affiliated organization.

However, the wisdom of this being the *sole* purpose of the trust is subject to some question. While imperatively needed at this time, there may be circumstances in the future making it no longer so necessary. In such event the fund could well lie dormant when there could be no other uses to which it could be put.

Within recent months, a bequest estimated to amount to $25,000 was left in trust for the education of future medical students providing they are graduates of a specifically named high school as well as residents of a particular city. This bequest was left by the widow of a physician who had long practiced in the community. Might such a bequest have been left in memory of that physician to a foundation of the State Medical Society had it been known to her?

Thus, it is increasingly evident that it would be desirable to establish a single organization which could receive scientific, educational, and charitable contributions from physicians and others and administer them in accordance with the intention of givers or in accordance with the best judgment of the management of such a body. Such an organization is commonly referred to as a "foundation." When it is organized in accordance with state and federal income tax laws, such an organization is *exempt* from such taxation. Further, gifts or grants made to such an organization are *deductible* by the givers, whether they be individuals or corporations. The fact of dual exemption makes a foundation attractive in these days of high taxes.

At its May 1954 meeting the Council authorized the study of such a foundation. While it need not be incorporated, experience seems to have demonstrated that the overwhelming majority of such organizations do take that form because their continuation is not as directly dependent upon individuals, as in the case of a trust or unincorporated association. Further, it is believed that there is a tendency on the part of givers to prefer that the object of their gifts be a corporation. They seem to attach an increased stability and likelihood of survival to an incorporated foundation.

The potentialities of a foundation are almost unlimited. Many unsolved scientific, educational, and economic questions have grown out of, or are related to, the practice of medicine today. They are the subject of much speculation and much writing for which there often exists no adequate factual basis. Many statements are made which represent either inadequate studies or confused conclusions. Medicine has a direct obligation to the people, as well as to itself, to determine or review facts underlying such problems and, where necessary, to state, restate, or correct conclusions. The very freedom of medical science may be dependent upon the manner in which these problems are studied and presented to the public. All too often the public accepts what appears to be an answer but what in fact is not an answer. The medical profession should study these problems and propose their solution as a matter of qualification, public interest, and legitimate self-interest.

A committee of the Medical Society has made a study during the past year of the causes of maternal deaths in the State of Wisconsin. It is now making a study of the closely associated subject of neonatal deaths. All such studies cost money. If several of them were to be conducted at one time, they could impose a heavy drain on the current dues structure or the reserves of the Society.

The advisability of enlargement of the funds to be available for loans to medical students would seem obvious. Much more complex would be the development of mechanisms for making grants to disabled physicians who might otherwise be public charges in part or in whole. Other professions have developed such mechanisms, and these fall clearly within the category of direct charity.

The medical profession or certain of its members might be interested in having special studies made in fields for which there were no other grants available. Medical men have commented that a few of the fields and problems of medicine have relatively generous funds available for their study at present, while others have nothing. The foundation might be able to correct this inequality in some measure. If such a foundation were already organized and had the funds available to it, undoubtedly its trustees would desire to make substantial contributions to the American Medical Education Foundation.

### Recommendations

The Council recommends the incorporation of a foundation and that it be governed by a Board of Trustees composed of (1) the Council of the Society, and (2) a representative elected by each component county society. It further recommends that the officers and members of the Executive Committee of the foundation be trustees who are also members of the Council. Terms of the county society members could be for three years, and so staggered that approximately one-third were elected each year, thereby helping assure stability. That would automatically be true in the case of the Council members.

While this would mean a board of approximately 70 members, it seems basically important that there be a representative in each county society who will be informed in the affairs of the foundation. This effective, continuing liaison at the county level would assure the success of the foundation better than any other single device.

In light of these various considerations, which have only been stated briefly, the Council recommends to the House of Delegates that it approve the organization of the proposed foundation with details to be completed early in 1955, so that the House may take further action at that time to implement the program. The following additional recommendations are offered:

(1) The foundation should be organized so that it may administer the Student Loan Fund of the Society if its trustees are willing to turn those funds and their administrative responsibilities over to the foundation.

(2) In the course of educating the membership to the existence and purposes of the foundation, it should be emphasized that gifts and grants should be made in broad terms or, in the alternative, so that if a particular problem has been solved before the funds are received, or reaches satisfactory solution before the funds have been fully expended, they can be diverted to other uses by the foundation. Such alternative uses could be determined by the foundation trustees unless they had been prescribed by the givers.

(3) Annual contributions from the membership should be established *by the House of Delegates* and be payable on a *voluntary* basis only. Such contributions would not be asked or expected of those under 35, but all other *active* members should be encouraged to contribute annually.

(4) After the foundation is under way, grants from industry and other sources for specific studies and other purposes would be received.

(5) In final determination of the details of the foundation, the House should approve giving authority to the Council to decide whether a limited but interested number of non-physicians should be included as trustees.

# REPORTS OF COUNCIL COMMITTEES

## COMMITTEE ON BLOOD BANKS

W. D. Stovall, chairman; C. N. Neupert; Tibor Greenwalt; and Paul Mason.

The major problem confronting the Committee on Blood Banks this past year has been that of relating the polio program and the distribution of gamma globulin to the procurement programs. Serving as an advisory committee to the state health officer, the committee assisted him in the development of the vaccine program along the lines finally put into operation.

### Local Blood Programs

During the year several communities have reported difficulties in maintaining local blood programs due to the fact that regular donors contribute to the Red Cross defense solicitations and thereby eliminate themselves for local solicitations at a time when blood is most needed. Efforts will be made to correct such situations if and when they occur.

### Regional and Defense Procurements

It is important that all physicians and hospitals have a complete understanding of the differences between regional and defense procurements through Red Cross, and how hospitals in each area can secure blood through Red Cross. In some situations it is evident that there is gross misunderstanding of the Red Cross program and the availability of blood on a "loan" basis. Before complaints are filed with the Committee on Blood Banks, it is urged that the matter be discussed with the responsible heads of the Red Cross blood centers in Madison or St. Paul, or the Junior League Blood Center of Milwaukee, whichever portion of the state is served by these three regional offices. (The Milwaukee Center serves Red Cross for defense purposes only.) Then, if there still is a basis for conflict of interest, the committee will undertake to correct the local problem.

Generally speaking, the blood programs in the state seem to be operating satisfactorily. The value of whole blood for many emergency uses suggests the need for each hospital to have ready access to types when needed. The Committee on Blood Banks in previous reports has recommended the setting up of a registry in each hospital as to blood types of patients and also possible donors. This is essential for local needs, and should a disaster occur, it would help save many lives.

## COMMITTEE ON CIVIL DEFENSE

M. J. Musser, chairman; E. P. Ludwig; K. E. Lemmer; J. S. Wier; and E. A. Bachhuber.

### Recommendations

The committee has the following recommendations concerning the State Medical Society's role in civil defense in Wisconsin:

1. The committee should function entirely in an advisory capacity to the state Office of Civil Defense.

2. The State Medical Society through its county societies should be responsible for assigning medical personnel to mobile medical teams and should make every effort to interest physicians in civil defense participation.

3. The county medical societies, particularly in the 29 counties where mobile medical teams are located, should have regularly established and active civil defense committees.

4. The medical profession should continue to arrange for first-aid training of non-professional personnel on civil defense mobile teams.

5. If Wisconsin contemplates a permanent civil defense organization in the health field, it is fundamental that there be an adequate corps of full-time personnel in the state Office of Civil Defense, including no less than one full-time staff member assigned to the mobile medical teams.

6. The state Office of Civil Defense must arrange an adequate training program, provide appropriate training aids, and influence public interest in the program through a vigorous publicity and educational program.

### Stimulation of the Public Needed

The crux of the current medical problem in civil defense is public and professional apathy. Almost nothing short of bombing will stimulate the public; and without the public the interest of the doctor cannot be sustained. Yet, the blind faith of the public cannot be shared by the medical profession in its attitude and responsibility for civil defense, now a permanent fixture on the American scene.

At the request of the state director of Civil Defense, the State Medical Society's Committee on Civil Defense has made several attempts to organize 100 mobile medical teams of 29 members each, including two physicians. Each time the initial enthusiasm and success have dwindled to nothing in the face of public disinterest and inadequate personnel to do the job. This, despite the very considerable expenditure of State Society staff time and facilities.

The situation prompts the committee to seek direction as to the extent of the Society's commitment in the civil defense activity in Wisconsin. Shall the Society's Committee on Civil Defense serve primarily in an advisory capacity, or shall it assume an operational role in the civil defense medical program in the state?

The former would require the continuation of regular committee activity by way of advising those concerned with health matters in civil defense; assignment of medical personnel, through the county medical society, to mobile medical teams; and genuine efforts to acquaint physicians with civil defense problems.

The latter would require the Society not only to provide medical personnel for mobile teams but to provide adequate staff assistance, time, travel, and supplies to assure proper recruitment, training, and stand-by status of a force of nearly 3,000 volunteers.

It is the belief of the committee that the vast problem of civil defense organization is essentially a public responsibility, and the agencies charged with that responsibility should have adequate personnel and financing to be able to do the job required for the safety of the people of Wisconsin. Therefore, the committee has made six recommendations which it feels can contribute much to the effective organization of Wisconsin's civil defense program.

### Progress Made

Despite the problems encountered in mobile medical team organization, there has been notable progress in civil defense in Wisconsin during the past year. Well over a quarter of a million dollars in supplies are currently stock-piled at Camp Williams awaiting packaging into units for distribution to mobile medical teams. It is anticipated that one complete unit of supplies, sufficient for 24 hours of operation during a disaster, will be assigned to each medical team captain during the coming year. It will be his responsibility to store the supplies at some point close at hand so that they may be kept safely, checked periodically, and be readily available in event of an emergency.

Numerous meetings have been held with state civil defense officials, and members of the committee participated in the nation-wide civil defense exercise known as "Operation Alert." The committee's efforts are currently being directed toward advising the state Office of Civil Defense on methods of dispatching casualties from the disaster area to numerous treatment centers, transportation of victims, organization of medical personnel for duty in hospitals outside the disaster area, and establishment of emergency hospitals to handle unusual numbers of casualties.

## COMMITTEE ON MILITARY MEDICAL SERVICE

F. L. Weston, chairman; M. J. Musser; J. M. Sullivan; M. H. Steen; and O. G. Moland.

### Recommendations

1. The continuation of the committee is essential if the interests of high quality medical care for the people of Wisconsin are to be maintained while at the same time meeting the needs of the military services for physicians.

2. The councilors of the State Medical Society are to be commended for their invaluable advice and assistance to the committee in its determinations of community medical needs. Their loyal service has been entirely voluntary, a contribution made at considerable personal expense and involving a real sacrifice of time and effort.

3. High praise and respect are due the Wisconsin headquarters of the Selective Service System for its efficient management of Selective Service calls for physicians. Colonel Bentley Courtenay, state director, and his staff have been most cooperative in understanding the peculiar problems of assuring adequate medical care for the entire state. The State Medical Society should also recognize the genuinely helpful attitude of the National Advisory Committee to Selective Service and the Armed Forces, particularly in the handling of reserve officer physicians.

### Need for Physicians

The need for physicians in the Armed Forces continues high. Nearly 4,000 physicians will be called to duty between July 1, 1954, and July 1, 1955. Wisconsin can expect to contribute its proportionate share.

This appears to be a peak year in the call-up of physicians. Most of those to be called have received at least part of their medical education at government expense or deferment during World War II but have not completed their period of obligated active duty. Included also is a large number of physicians under 32 years of age who are registered under the regular draft who have never had military duty.

There is reason to believe that the Armed Forces can obtain its requirement of 4,000 physicians without resorting to the "draft" of physicians above the age of 32.

The special Doctor Draft Law expires on July 1, 1955. After that date physicians for the armed services are expected to be supplied entirely from the continuing group of men completing internships and residencies each year.

### Physicians in Education

It is reported that a plan is under way for the establishment of an orderly system of calling physicians upon completion of their medical education. It contemplates that most physicians will be called to duty immediately upon completion of their internships. A limited number will be permitted to complete one, two, three, or four years of residency training as a means of preventing complete disruption of the nation's medical education system. This committee, recognizing the problem of the teaching hospital, has urged both the American Medical Association and the National Advisory Committee to Selective Service to effect such a plan at an early date.

### Record Keeping and Advice

The seemingly simple task of record keeping for military medical service offers the committee a continuing problem of considerable proportions. Active files must be maintained on nearly 900 physician registrants in the first three priorities. Another 1,200 physicians are in Priority IV but currently are not under military consideration.

The committee must run constant checks on the availability of hundreds of physicians from Wisconsin and elsewhere who are in various stages of processing under Selective Service or reserve regulations. Each week about 50 inquiries are received at the State Medical Society headquarters concerning these individuals.

The committee has increasingly become the source of help for physicians seeking advice on military matters. Communities faced with the loss of medical personnel to the military service often make significant demands upon the time of the committee as well as the facilities of the Society. By mail, telephone, and personal contact, members of the committee are constantly being sought out by those individuals and groups whose lives and activities feel the impact of the military's demands for physicians.

It is difficult to report the effort or the effect of the committee's work. The task is assumed willingly; yet, the membership should recognize that the very existence of the committee and the implementation of its work by the staff constitute another important "service" of the State Medical Society to the physicians and the people of Wisconsin.

## WISCONSIN VETERANS MEDICAL SERVICE AGENCY OPERATING COMMITTEE

J. S. Supernaw, chairman; Maurice Hardgrove; W. A. Fischer; Otto A. Dittmer; and C. E. Koepp.

The State Medical Society of Wisconsin, through its Veterans Medical Service Agency, operates the program known as the Home-Town Care Program for Veterans. It has operated continuously since 1946 in cooperation with the Veterans Administration.

TOTAL VALUE OF BUSINESS WITH THE VETERANS ADMINISTRATION

| | July 1, 1952 through June 30, 1953 | July 1, 1953 through June 30, 1954 |
|---|---|---|
| Total authorizations received from the Veterans Administration | $171,268.18 | $137,609.22 |
| Total authorizations cancelled | 17,998.94 | 15,923.65 |
| Unused authorities | 26,198.54 | 12,056.48 |
| Total cash paid to physicians | 136,170.98 | 114,392.25 |
| Total amount received from Veterans Administration for administrative expenses | 19,210.91 | 15,995.52 |

The contract existing between the State Medical Society and the Veterans Administration is on a year-to-year basis, and it operates on a cost basis for administration.

Home-Town Care of the Veteran is limited, for all practical purposes, to home and office calls and laboratory procedures. Only emergency cases of hospitalization are approved.

The surgical part of the fee schedule is used very little, because the Veterans Administration desires to have surgical work performed at the Veterans Administration hospitals as much as possible. By renegotiation, the surgical section of the fee schedule was changed so that effective July 1, 1954, the surgery schedule of the Veterans Program is the same as the surgery schedule of the Blue Shield "A" program.

A study was made of the June invoices paid. There was a total of 978 invoices. Sixty-eight per cent of these were $10 and under; 18½ per cent were from $10 to $20; 10½ per cent, from $20 to $40; and 3 per cent, over $40.

WISCONSIN VETERANS MEDICAL SERVICE AGENCY

CERTIFIED FINANCIAL STATEMENT

December 31, 1953

| | | |
|---|---|---|
| **ASSETS** | | |
| **Current Assets** | | |
| Cash in Bank—Administrative Fund | $ 5,265.80 | |
| Cash in Bank—Medical Fund | 2,595.82 | |
| Medical Claims Filed with Veterans Administration | 9,642.38 | |
| Administrative Claims Filed with Veterans Administration | 1,312.71 | |
| Unfiled Administrative Claims | 10.00 | |
| Total Current Assets | | $18,826.71 |
| **Fixed Assets** | | |
| Office Furniture and Fixtures | $ 2,434.17 | |
| Less: Accumulated Depreciation | 1,512.68 | |
| Total Fixed Assets | | 921.49 |
| Total Assets | | $19,748.20 |
| **LIABILITIES** | | |
| **Current Liabilities** | | |
| Due Doctors on Claims Filed | $12,238.20 | |
| Accounts Payable | 10.00 | |
| Total Liabilities | | 12,248.20 |
| **Advance from State Medical Society of Wisconsin** | | |
| Balance of Cash Advance—December 31, 1953 | | $ 7,500.00 |

Certificate

I have audited the accounts of the Wisconsin Veterans Medical Service Agency, a Division of the State Medical Society of Wisconsin, Madison, Wisconsin, for the period July 1, 1953, to December 31, 1953, and

I hereby certify that, in my opinion, the above Financial Statement fairly represents the financial condition of the agency on December 31, 1953, and the result of its operations for the period July 1, 1953, to December 31, 1953, in conformity with generally accepted accounting principles.

/s/ Donald E. Gill
*Certified Public Accountant*

Madison, Wisconsin
August 9, 1954

## THE COMMISSION ON PREPAID PLANS

E. M. Dessloch, chairman; Robert Krohn, vice-chairman; N. A. Hill, treasurer; John T. Sprague, assistant treasurer; H. E. Kasten; W. T. Casper; R. E. Garrison; K. H. Doege; Milton Finn; J. S. Supernaw; H. A. Aageson; R. M. Moore; C. G. Reznichek; Richard Foregger; G. W. Carlson; P. B. Mason; and H. Kent Tenney, president of Society.

### INTRODUCTION

A year ago the Commission on Prepaid Plans made a detailed report to the House of Delegates which filled 39 pages of the Handbook for Delegates. That report provided physicians with a comprehensive description of "Operation Big Switch"—the conversion to the "A" and "B" schedules and the many internal ramifications of the new program.

The Commission on Prepaid Plans now reports on the first full year of operation since the "Big Switch." This, too, has been a year of change, not so much in administration as in the way of offerings to the public. The Commission believes that medicine must have more to offer than a single product as those who buy do not have the same requirements and yet wish the protection of a professionally sponsored plan. It believes that the demands of the people are governed in part by where they live, how they are employed, and the status of their pocketbooks as well as the condition of their health. During the past year new programs have been developed which attempt to meet certain needs and desires which are dictated by these facts of life. Physicians, statisticians, actuaries, attorneys, accountants, claims administrators, salesmen, and others familiar with the problems have met repeatedly, month after month, to carry on the business of the Society's efforts in the prepaid field. Their individual, day-to-day contributions have been blended in this report for a concise statement of operations during the past year.

### WISCONSIN PHYSICIANS SERVICE

The Commission is able to report that the plan experienced sound growth during the 12 months ending June 1954, from the financial point of view. It

**WISCONSIN PHYSICIANS SERVICE**
**Madison, Wisconsin**
**BALANCE SHEET**
**June 30, 1954**

| | | |
|---|---|---|
| **Assets** | | |
| Cash on Hand and in Banks | | $ 588,055.65 |
| Cash on Deposit with Agent | | 117,000.00 |
| Due from Agent | | 42,626.75 |
| Advance to Physicians Indemnity Plan of Wisconsin | | 25,000.00 |
| Refunds Receivable | | 3,116.00 |
| Accounts Receivable | | 7,092.23 |
| U. S. Government Bonds—Net | $1,455,783.56 | |
| Accrued Interest Income | 6,630.74 | 1,462,414.30 |
| Office Furniture and Fixtures—Net | | 16,371.52 |
| Total Assets | | $2,261,676.45 |
| **Liabilities and Reserves** | | |
| Accounts Payable | | $ 7,110.03 |
| Merit Rating Credits Payable | | 5,068.91 |
| Physicians Claims Payable | | 359,790.11 |
| Reserve for Old Outstanding Checks | | 2,387.50 |
| Unearned Income | | 383,872.75 |
| Reserves—Maternity Benefits | $ 194,400.00 | |
| Disaster Claims | 236,956.00 | |
| Unforeseen Contingencies | 557,045.79 | |
| Administrative | 464,847.77 | |
| Investment | 50,197.59 | 1,503,447.15 |
| Total Liabilities and Reserves | | $2,261,676.45 |

**WISCONSIN PHYSICIANS SERVICE**
**Madison, Wisconsin**
**Comparative Statement of Income and Expenditures for the periods January 1 to June 30, 1953 and 1954**

| | 1-1-54 to 6-30-54 | 1-1-53 to 6-30-53 | Increase or (Decrease) |
|---|---|---|---|
| **Income** | | | |
| Earned Premium Income | $2,086,697.48 | $1,890,712.69 | $195,984.79 |
| Other Administrative Income | 4,787.60 | ---------- | 4,787.60 |
| Investment Income | 14,243.27 | 7,450.76 | 6,792.51 |
| Total Income | $2,105,728.35 | $1,898,163.45 | $207,564.90 |
| **Expenditures** | | | |
| Benefits Incurred | $1,616,392.85 | $1,530,744.35 | $ 85,648.50 |
| Expenses of Agent | 151,079.57 | 171,793.88 | ( 20,714.31) |
| Salaries | 61,420.79 | 54,574.32 | 6,846.47 |
| Legal Expense | 6,163.12 | 3,492.00 | 2,671.12 |
| Auditing Expense | 3,471.04 | 2,620.59 | 850.45 |
| Actuarial Expense | 6,917.41 | 3,125.56 | 3,791.85 |
| Conference Expense | 8,557.28 | 7,748.96 | 808.32 |
| Staff Travel | 4,593.88 | 4,302.77 | 291.11 |
| Stationery and Supplies | 2,109.58 | 4,428.94 | ( 2,319.36) |
| I.B.M. Expense | 6,022.62 | 3,599.48 | 2,423.14 |
| Rent | 5,445.00 | 4,950.00 | 495.00 |
| Office Expenses | 1,191.61 | 1,244.89 | ( 53.28) |
| Postage and Express | 2,158.71 | 2,521.21 | ( 362.50) |
| Payroll Taxes | 2,195.50 | 1,739.53 | 455.97 |
| Telephone and Telegraph | 1,427.91 | 2,469.71 | ( 1,041.80) |
| Employees' Group Insurance | 822.03 | 767.35 | 54.68 |
| Depreciation | 1,299.58 | 925.35 | 374.23 |
| Insurance | 227.40 | 306.86 | ( 79.46) |
| Association Dues | 1,977.16 | 1,722.52 | 254.64 |
| Conservation and Promotion | 4,252.68 | ---------- | 4,252.68 |
| Other Administrative Expenses | 2,040.37 | 324.36 | 1,716.01 |
| Total Expenditures | $1,889,766.09 | $1,803,402.63 | $ 86,363.46 |
| Available for Reserves | $ 215,962.26 | $ 94,760.82 | $121,201.44 |
| **Distribution of Each $100 of Income** | | | |
| Benefits Incurred | $ 76.76 | $ 80.64 | $( 3.88) |
| Expenses of Agent | 7.17 | 9.05 | ( 1.88) |
| Other Administrative Expenses | 5.81 | 5.32 | .49 |
| Additions to Reserves: | | | |
| Service Benefit Reserves | 4.44 | 1.03 | 3.41 |
| Administrative Reserve | 5.14 | 3.57 | 1.57 |
| Investment Reserve | .68 | .39 | .29 |
| | $ 100.00 | $ 100.00 | $ --------- |

had the largest income and paid the largest number of claims of any year in its history. The conversion of all its contracts from the old to the new program was successfully completed. New types of coverage were developed. The staff for conservation and sales was expanded, and the plan was able to increase its reserves.

In so far as numbers are concerned, the plan merely held its own. At the end of the year 1952, the plan had 115,490 contracts outstanding, for a total of 283,672 persons covered. A year later enrollment had increased to 118,380 contracts and 295,747 persons covered. By June 30 of this year the number of contracts in force had decreased to 117,456, and the number of persons covered was down to 294,439. However, the remaining six months of 1954 provide some opportunity to regain these losses and achieve a net gain.

The losses were occasioned primarily by cancellations resulting from a Blue Cross rate increase on May 1, 1954. Because subscribers to Blue Shield and Blue Cross generally look at the total cost of both programs, rather than the cost of each, this rate increase had a substantial effect on WPS sales. Blue Cross representatives who sell WPS had to spend the vast majority of their time trying to retain existing accounts rather than selling new business. If it can be assumed that rates are now stabilized for a reasonable period of time, the adverse effects of the last rate increase will eventually pass; and new business sales activities can go ahead unhampered.

In connection with sales it is important to note that a Blue Shield office, staffed by a district sales coordinator, has been opened in Appleton. This office will service Blue Shield installations in northeastern Wisconsin and aid in new sales.

Benefit payments during the year ending June 30, 1954, hit an all-time high at over $3,000,000. This is an increase of slightly more than $500,000 over the same period ending June 30, 1953. During that year benefit payments totaled about $2,500,000.

A substantial portion of this increase in benefit payments is the result of expanded benefit provisions of the "A" and "B" contracts. The full force of these provisions was not felt during 1953 since the conversion was not completed until midyear. The increase in benefit payments for in-hospital medical care, anesthesia, and radiology and increased usage of these benefits accounted for over half of the $500,000 increase in total payments.

This increase is reflected also by the growth in the number of claims handled by the claims department. During the year ending June 30, 1954, the department handled 71,080 cases, or an average of 5,923 cases per month. This represents an increase of nearly 2,000 cases over the previous 12-month period.

Statistical studies reveal several interesting facts concerning the benefits paid under the "A" and "B" contracts and the payments made to physicians and subscribers. These are shown graphically on page 647.

The claims department continues to analyze its procedures with a view to more efficient operation. A medical student has been employed on a part-time basis to audit claims. In cooperation with the anesthesiologists steps have been taken which simplify the problem of reporting for anesthesia services.

Studies have been conducted which show that the elapsed time from the day the patient was admitted to the hospital until a claim is approved for payment is an average of from 17 to 20 days. The Commission is satisfied that this is a reasonable degree of efficiency and service.

The statistical department now has a sufficient installation of IBM equipment to enable it to make four payments each month to physicians who have rendered services to Blue Shield subscribers. It is worth noting also that a study of home and office procedures over a nine-month period reveals that 85 per cent of these procedures resulted in payments of $15 or less. The average cost per procedure was $11.58.

The Claims Committee of the Commission meets regularly to handle unusual cases, review claims procedures, and conduct special studies. A part-time medical director advises the claims department on a more continuing basis.

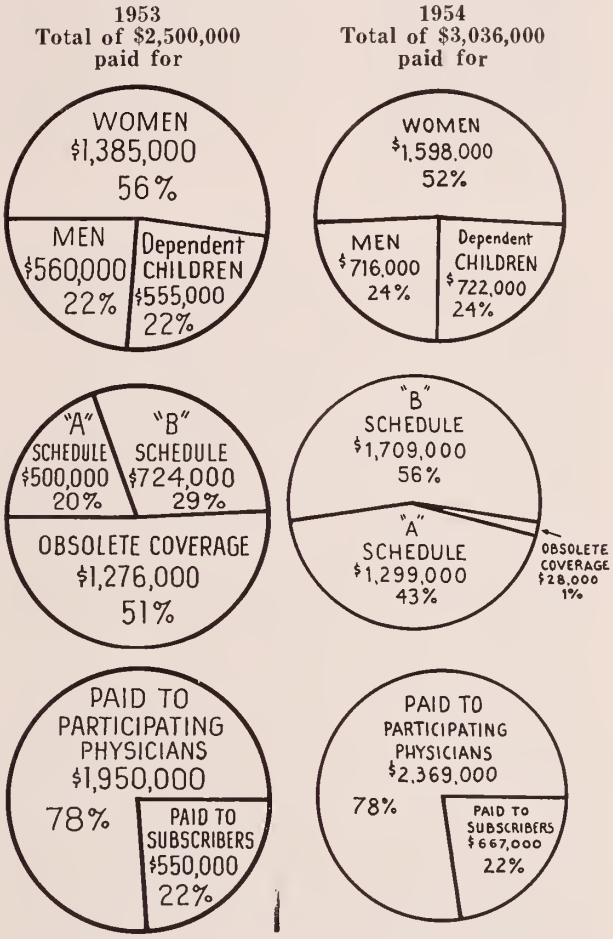
Wisconsin Physicians Service is currently operating under a new agency contract with Associated Hospital Service, Inc. (Wisconsin Blue Cross). Renegotiation of the contract was instituted by WPS in June 1952, and the new agreement was concluded in April of this year. It is impossible to evaluate the financial outcome of the negotiations. On the other hand, the provisions of the new contract represent a substantial improvement over those of the old in that they are more specific on many points of administrative importance.

One of the most significant developments of the year has been the offering of major illness expense insurance. Several thousand hours of time on the part of the Commission, the staff, and the plan consultants were spent developing this program. At the present time it is available to groups of 50 or more which can qualify according to the special underwriting conditions. The plan offers a variety of deductible features; a maximum of $5,000 per person per disability; a full-payment feature for physicians' services; benefits of 80 per cent of reasonable charges for a wide variety of related health services; and, where Blue Cross does not provide a catastrophe benefit, a per diem varying between $10 and $25 per day for persons hospitalized more than 70 days. Payments of the latter benefit will be direct to the subscriber and not to the hospital, and no dealings will be had with hospitals. It is estimated that perhaps two years of "exposure" will be needed before a significant number of contracts can be obtained.

Starting May 1, 1954, Wisconsin Physicians Service offered maternity benefits along with surgery, in-hospital medical care, x-ray, and anesthesia for non-group subscribers. It is now possible for non-group subscribers to have identical benefits with those enrolled in groups, subject, however, to waiting periods and appropriate underwriting requirements. The Commission has long been concerned over the problem of covering that substantial part of Wisconsin's population which is not able to enroll in Blue Shield through the medium of a group. These are the farmers, small businessmen, and other self-employed individuals. As of June 30, 1954, only about 17,000 persons were covered by Blue Shield of Wisconsin on a non-group basis.

WISCONSIN PHYSICIANS SERVICE PAYMENTS

Comparison of Payments Made During 12 Months Ending June 30, 1953 and 1954




Community enrollment drives conducted by Blue Cross and Blue Shield in Manitowoc and Monroe counties have not been successful in terms of numbers of non-group contracts. As a specific effort to reach people in the non-group category, the Commission has launched an enrollment program in northwestern Wisconsin which involves the counties of Polk, Barron, Burnett, and St. Croix. An arrangement has been made with a well-established insurance agency to conduct direct selling efforts through its several full-time and part-time agents located throughout these counties. The first sales contacts are being made as this report is written. It is hoped that substantial progress can be reported a year hence.

In the process of development is another program known as an "All Star Contract," which will eventually be available to enrolled groups. The benefits to be included in the contract are home and office medical calls on some type of deductible basis; diagnostic studies related to a disability (not routine physical examinations); therapeutic x-ray and radium on a scheduled basis; first-day surgery for the newborn; and certain benefits for the services of dentists.

A most encouraging development is the increasing number of Wisconsin physicians who are "participating physicians" in the Society's prepaid programs. Two thousand, three hundred and ninety-eight physicians are now enrolled as participants out of the 2,853 physicians available to the general public through private practice. There is 100 per cent participation in many counties and sufficient participation in the others to make the full-payment provisions of the Medical Society's program an effective reality.

### PHYSICIANS INDEMNITY PLAN

**It continues to be the opinion of the Commission, as it is the express policy of the House of Delegates and the Council, that the principle of full payment is perhaps the most fundamental contribution that medicine can bring to the prepayment movement.** On the other hand the Commission is aware of indemnity contracts written by many of the large Blue Shield plans of the country, and that, in some respects, elements of indemnity continue to exist in its own programs.

As a result of contracts negotiated by the national agencies of Blue Cross and Blue Shield with the packing industry, the Council authorized the Commission to write an indemnity program with two well-known packing firms in Wisconsin. This contract has been written since last December 1 under the identification of "Physicians Indemnity Plan." From December 1, 1953, to June 30, 1954, the plan has paid for a total of 1,251 cases amounting to nearly $65,000.

The issue which prompted the decision to establish Physicians Indemnity Plan was whether Blue Shield of Wisconsin would permit the National Blue Cross Insurance Company (and its reinsurance agent, National Blue Shield) to write surgical–medical insurance in Wisconsin under the name Blue Shield. The Commission felt that such a step would create unthinkable confusion for physicians and subscribers alike with two Blue Shield plans—one, indemnity, and the other, full payment—in force in the same area at the same time. There have been many complications in the administration of the program, but the Commission felt compelled to protect the fundamental characteristics of Wisconsin Blue Shield.

### THE WISCONSIN PLAN

Eleven large insurance companies participate in the Wisconsin Plan. Each reimburses the Society for all expenses incurred by it for such services as reviewing policies, preparing panels of participating physicians, claims advice, and related administrative tasks.

A considerable volume of cases was reviewed during the past year on behalf of the companies participating in the Wisconsin Plan. The cases under consideration were primarily those in which the Society was asked to assist the companies in determining their full liability for benefits. The Commission believes this to be an essential service and one that is of mutual benefit to policyholders, insurance companies, and physicians.

## THE COMMISSION ON STATE DEPARTMENTS

T. W. Tormey, Jr., chairman; H. A. Anderson; Robert F. Purtell; Maxine Bennett; Henry A. Sincock; E. H. Pawsat; Ray Piaskoski; John Schindler; H. W. Carey; and E. D. Schwade.

The primary function of the Commission on State Departments is to afford an opportunity for heads of state boards and commissions most immediately concerned with health problems to exchange views and to place before the State Medical Society special problems concerning health. While the Commission is still new and is "feeling its way," it has already provided many avenues through which better cooperation between departments of state government in Wisconsin has been attained.

Each of the Divisions under the direction of the Commission has carried on an active program this past year, as a review of the separate reports which follow will reveal. The work of the Commission through its separate Divisions has been monumental and has commanded the time and effort of nearly 100 physician members. Many projects undertaken have been completed and are reported to the House of Delegates for review and approval. Other projects are of a continuing nature and will command further study before specific recommendations can be made. This is particularly true in the field of public assistance. There is need for much more local study on this subject by county medical societies so that policies on the state level can be developed in the best interests of all concerned.

The Commission hopes that the House of Delegates will give careful consideration to the various recommendations provided as the major portion of this report and will give the Commission further guidance as to ways in which the State Medical Society can be of greater assistance in the coordination of activities of governmental agencies.

## DIVISION ON CRIPPLED CHILDREN

H. A. Sincock, chairman; J. W. Nellen; D. W. McCormick; R. C. Waisman; M. G. Peterman; Kate P. Newcomb; F. D. Bernard; and A. B. Weinstein.

This Division has continued to serve in an advisory capacity to the Bureau of Handicapped Children. For the past year it received a detailed report of the Bureau's activities, indicating that in Wisconsin there is a registry of approximately 62,000 handicapped children under the age of 21 years. Of this

number, approximately 14,000 have handicaps which are met through programs of the Bureau, and approximately 11,000 actually take part in the programs offered.

The orthopedic clinics continue to serve a large number of children with 40 such clinics held in 1953 in contrast to 36 clinics in 1950. This past year the 40 clinics handled 2,619 cases, with 577 being initial examinations. It was reported that of the 46 orthopedists in the state, 14 are actively participating in the program.

The report indicated a shift in emphasis in regard to the orthopedic program. With more specialists available in areas outside of Milwaukee and Madison, there is a growing tendency to have corrective therapy carried on in local hospitals, rather than refer patients to the Orthopedic Hospital in Madison. There is need for a closer study of this situation, and it is suggested that special attention be directed to this matter during the ensuing year and that future report and recommendations be made to the House of Delegates.

The report of the Bureau indicated a need to develop regional rheumatic fever programs along the lines of that being conducted in Dane County, and it is urged that some of the more populous counties consider this as a special project and become better acquainted with the procedures carried on in Dane County. Visits and consultations with those in charge of the program can be arranged by contacting Mr. Frank Powell at the Bureau of Handicapped Children, Department of Public Instruction, State Capitol, Madison, or contact may be made directly with Dr. A. B. Weinstein, Madison. Suggested procedures for the establishment of rheumatic fever programs have been sent to all county societies, and it is hoped that these will be used as regional programs are developed.

### Recommendations

1. Full cooperation should be given to the continuance of the orthopedic clinics, both by way of referrals and, when possible, by direct participation in the examination of patients referred, so that a complete understanding of follow-up therapy can be attained, and the recommendations of the orthopedic specialist conducting the examination can be carried out most effectively.

2. Special attention should be directed in the more populous counties to the establishment of a rheumatic fever program with full recognition that home therapy, with a clinic maintained on an outpatient basis, can meet many problems without setting up a specialized facility. It is urged that county societies consider the establishment of programs along the lines of that being conducted in Dane County and that the assistance of the Bureau of Handicapped Children be employed to formulate details of a program designed to meet local needs.

## DIVISION ON GERIATRICS

J. A. Schindler, chairman; A. M. Hutter; M. T. Morrison; M. J. Musser; C. A. Olson; Owen Otto; G. G. Stebbins; Millard Tufts; and R. H. Quade.

The Division on Geriatrics of the Commission on State Departments has taken as one of its projects the development of a guide that might be used by county medical societies in regard to the establishing of nursing homes.

A subcommittee was appointed to study the problem further and to devise a draft guide that might be presented to county medical societies. This draft has been prepared and has been forwarded to the committee members for evaluation.

The committee has taken no action on the proposed guide as yet but it is considering five different topics: What is a nursing home? Is a nursing home needed? Where shall a nursing home be built? What kind of a building should it be? What is the relationship of the practicing physician to the nursing home as regards free choice by the patient?

The Division on Geriatrics Committee is watching with interest the results of a study being conducted in Dane County regarding health needs, services, and facilities for the aging and long-term patients. Results of this study will be made available by the Dane County Medical Society, and the Division will benefit from its findings.

The Division has also taken under advisement a suggestion that institutes on medical, social, and economic problems of the aged be conducted in Wisconsin.

A subcommittee of the Division has been appointed to study and report on "Geriatric Factors in Automobile Accidents."

## DIVISION ON MATERNAL AND CHILD WELFARE

Robert F. Purtell, chairman; E. A. Birge; T. V. Geppert; F. G. Johnson; G. S. Kilkenny; A. H. Stahmer; D. D. Willson; J. D. Wilkinson; and Amy L. Hunter.

A number of important projects have been conducted by this Division during the past year. To simplify the summary of activities, only the high lights will be presented. If further details are desired, the chairman of the Division or the chairman of the Study Committee of the Maternal Mortality Survey will be available for verbal amplifications.

TABLE I.—PREMATURE DATA—1952 AND 1953

Wisconsin Resident Figures

| Birth Weight | Live Born | | | Dying | | | % Dying |
|---|---|---|---|---|---|---|---|
| | 1952 | 1953 | Total | 1952 | 1953 | Total | |
| 1 Lb. 1 Oz. or less | 67 | 74 | 141 | 61 | 74 | 135 | 95.7 |
| 1 Lb. 2 Oz. to 2 Lbs. 3 Oz. | 315 | 280 | 595 | 294 | 262 | 556 | 93.4 |
| 2 Lbs. 4 Oz. to 3 Lbs. 4 Oz. | 422 | 423 | 845 | 240 | 238 | 478 | 56.6 |
| 3 Lbs. 5 Oz. to 4 Lbs. 6 Oz. | 1,020 | 993 | 2,013 | 242 | 220 | 462 | 23.0 |
| 4 Lbs. 7 Oz. to 5 Lbs. 8 Oz. | 3,555 | 3,610 | 7,165 | 229 | 247 | 476 | 6.6 |
| Unknown weight | 141 | 119 | 260 | 99 | 89 | 188 | 72.3 |
| Total | 5,520 | 5,499 | 11,019 | 1,165 | 1,130 | 2,295 | 20.8 |

### Maternal Mortality Survey

A total of 66 cases has been studied, and all cases in which pregnancy or delivery was considered as contributory to, or as responsible for, death were covered by direct interview. On deaths obviously not related to pregnancy, such as auto accidents or cancer, basic information was obtained by correspondence. All cases have been reviewed by the Study Committee without identity and on a truly scientific basis to appraise problems fairly and consider all factors that might have influenced outcome.

It is the opinion of the Study Committee, as well as the Division, that the individual review of case summaries and statistics will be of less value than a more detailed scientific presentation of more recent knowledge and trends in care of the various conditions with which maternal deaths were associated. It is hoped that the composite reviews will provide the maximum background for handling similar or related situations in the future.

Augmenting the interpretive material, the Division has prepared a series of slides and discussion material. It is hoped that every hospital staff and every county medical society will schedule one meeting at which a speaker familiar with this material may appear. Members of the Study Committee and the interviewers who assisted are available as speakers. All hospital staffs and county societies have been informed of this service, and it is urged that all participate in this important phase of the study program.

It might be well to remind members of the House of Delegates that this study has been made possible through the financial support of the Bureau of Maternal and Child Health of the State Board of Health, which provides payment to interviewers for their services, and through the State Medical Society in providing substantial facilities and assistance.

Special recognition should be extended to the Study Committee, whose members are required to meet frequently to study cases and to prepare summaries for the attending physicians. Committee members have accepted this responsibility at a considerable sacrifice, and their contribution to the study should be especially recognized by the House.

It is also gratifying to report that the fullest cooperation has been extended on the part of the attending physician to the interviewer and to the Study Committee. The attending physicians have expressed a desire to have assistance by way of a summary and supporting material to help them meet similar problems in the future. This attitude reflects the high quality of medical practice in Wisconsin and indicates partially why Wisconsin has a good record in respect to maternal deaths.

The study would indicate that some physicians may not realize that they have the privilege of correcting data on death certificates. It appears that when postmortem findings are not completed until after death certificates are filed, the supplemental data which might change the diagnosis occasionally does not reach the proper authorities. Causes of death are determined entirely from the physician's entries on the certificate. If additional information becomes available after certificates have been filed, this supplemental information should be forwarded to the proper authorities—the local health departments in urban areas or the local registrars in rural territory. Corrections are then forwarded to the State Board of Health.

### Fetal-Neonatal Study

Some hospitals where pathological service was available were asked to participate in a preliminary study of near-birth infant losses associated with pregnancy or delivery. Statistics, reviewed preliminary to launching this study and again this year, emphasized the fact that the problem of further reducing loss of Wisconsin babies is intimately tied up with learning ways and means of carrying more mothers to term before delivery.

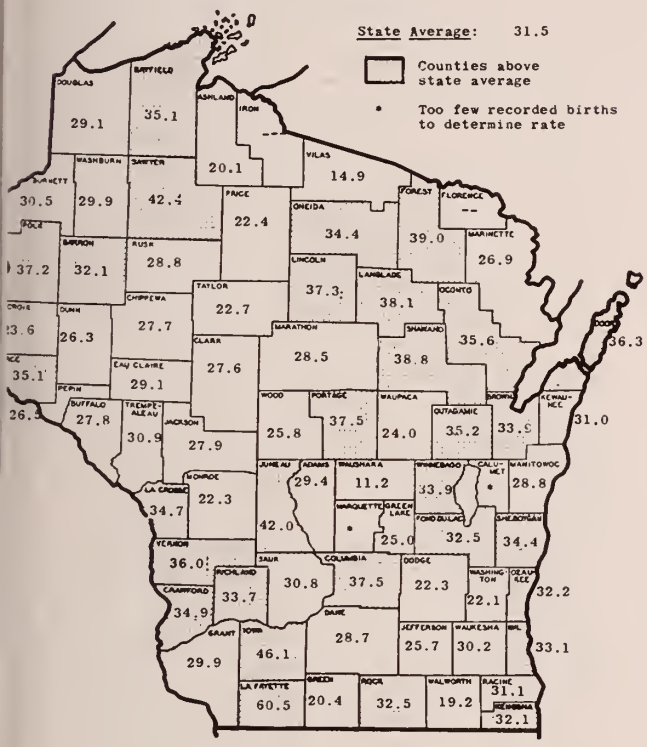
In 1953 there were 6.2 per cent of live births, or 5,499 deliveries, in which the baby weighed less than 5 lbs. 8 oz. If we could return to as low as the 2.7 per cent of premature deliveries which occurred in as recent a year as 1939, we would have had only 2,387 prematures in 1953, and the over-all near-birth loss would have been cut at least in half.

State statistics (Table II) show that with the exception of congenital malformations accounting for the death of 85 premature and 169 term infants, loss was primarily in four groups: (1) other birth injuries, including placenta praevia, cord complications, abnormal presentations, and dystocia; (2) immaturity unqualified; (3) asphyxia and atelectasis; and (4) maternal toxemia.

For the study questionnaires were prepared and supplied to cooperating hospitals for collecting data on each fetal or neonatal death occurring in 1954. More than 500 reports have already been filed. These case reports, without identifying information, will be tabulated and reviewed by special teams made up of a pediatrician, obstetrician, pathologist, and gen-

COMBINED FETAL-NEONATAL DEATH RATE PER 1000 LIVEBIRTHS

Recorded Data - Wisconsin 1953




eral practitioner. While it is too early to report on this project, it is hoped that the findings will suggest methods which hospitals might employ to salvage some of the lives now lost prior to or immediately following delivery. The preceding map showing the 1953 combined rate of fetal-neonatal loss by county may serve as a guide in locating problems.

### Institutes on Premature Care

Recognizing the joint responsibilities of physicians and nurses in proper care of prematures in hospitals, the Division has sponsored a series of institutes held at Milwaukee Hospital Maternity Pavilion and St. Mary's Hospital, Madison. All hospitals concerned with the fetal-neonatal study were invited to send "teams" of nurse and physician to these two-day conferences. The demand was so great for the first meetings that a second course was arranged at each hospital. The response from those attending indicates the value of this service. Other hospitals have expressed a desire to participate in future courses. If the two hospitals and the physicians and nurses in charge of the instruction are willing, similar courses will be arranged during the ensuing year. A special note of thanks is extended to the administrators of the Milwaukee Maternity Pavilion and St. Mary's Hospital for the use of their facilities and their fine cooperation in making their staffs available to assist with this project.

Every effort must be made to provide the best possible chance for babies weighing 5 lb. 8 oz. or less to live. In the group of immature infants approximately one of five dies during the first 28 days of life, while the term baby has 32 times that chance of surviving beyond this neonatal period. Even after the first 28 days a premature infant's chance of survival through the first year is only one-fourth that of a term infant. Deaths occur at the rate of 1:42 for prematures as compared to 1:181 for term infants. Recognizing this, even closer supervision of prematures throughout the first year of life and further instruction of parents may reduce respiratory and digestive disturbances or other illnesses which take a high toll.

### Anesthesia Study

The Maternal Mortality Study Committee has indicated the advisability of reviewing anesthesia practices, and plans have been made to conduct a spot survey through the hospitals cooperating in the fetal-neonatal study. It is hoped that by the time the next report of this Division is placed before the House of Delegates this project will be well under way.

### Suggested Change in Statutes Concerning Treatment of Newborn

It has been recommended to the Division that consideration be given to modification of Section 146.01 of the Wisconsin Statutes concerning the application of silver nitrate to the eyes of the newborn so as to

**TABLE II.—NEONATAL AND FETAL DEATHS**
**1953 Wisconsin Resident Data**

| CAUSES | NEONATAL | | | | FETAL | | | |
|---|---|---|---|---|---|---|---|---|
| | Prem. | Term | Total | % Prem. | Prem. | Term | Total | % Prem. |
| Cerebral and Sp. Birth Injury | 19 | 50 | 69 | 27.5 | 2 | 3 | 5 | 40.0 |
| "Other Birth Injury" | 371 | 68 | 439 | 84.5 | 189 | 231 | 420 | 45.0 |
| Immaturity | 325 | 3 | 328 | 99.1 | | | | |
| Congenital Malformation | 85 | 169 | 254 | 33.5 | 69 | 54 | 123 | 56.1 |
| Atelectasis and Asphyxia | 106 | 55 | 161 | 65.8 | | | | |
| Rh Factor | 23 | 51 | 74 | 31.1 | 47 | 30 | 77 | 61.0 |
| Maternal Toxemia (Incl. Diab.) | 48 | 11 | 59 | 81.4 | 73 | 48 | 121 | 60.3 |
| Pneumonia of Newborn | 12 | 22 | 34 | 35.3 | | | | |
| All Other Known | 13 | 46 | 59 | 22.0 | 83 | 93 | 176 | 47.2 |
| Ill Defined or Unknown | 22 | 9 | 31 | 71.0 | 207 | 122 | 329 | 62.9 |
| Total | 1,024 | 484 | 1,508 | 67.9 | 670 | 581 | 1,251 | 53.6 |
| Total Over One Month | 106 | 455 | 561 | 18.9 | | | | |
| Total Infant | 1,130 | 939 | 2,069 | 54.6 | | | | |
| % Neonatal | 90.6 | 51.5 | 72.9 | | | | | |

permit the use of antibiotics as an alternative procedure. The Division is conducting a study of practices in other states, and it seems premature to suggest a definite change at this time. Further study will be directed to this subject during the ensuing year, but for the present the Division recommends continuation of practices as outlined in Section 146.01.

### Recommendations

1. Every hospital staff and county medical society should be requested to set aside one meeting this coming year at which time a member of the Study Committee or one of the assisting interviewers can present the findings and conclusions of the maternal mortality study to date.

2. All doctors and hospital staffs should be reapprised of the necessity of weighing carefully the sequence of events when completing death certificates. Accuracy is extremely important. If supplemental information is obtained from a postmortem examination after a certificate is filed, a supplemental or corrected report should be filed with the proper authority.

3. Special attention should be directed in all hospitals to the care of the immature infant; and if future courses on this subject are arranged, every hospital which has not participated should be encouraged to do so by selecting one physician and one nurse to form a "team" for the instructional course.

4. Hospital staffs should be urged to explore ways and means of increasing the number of pregnancies carried to term, since the immature infants accounted for 72.9 per cent of the near-birth infant loss and 53.6 per cent of fetal loss.

5. Studies should be directed to anesthesia practices related to obstetrics, with special attention to the role of caudal anesthesia and its proper application when employed.

## DIVISION ON NERVOUS AND MENTAL DISEASES

E. D. Schwade, chairman; Owen Clark; Roland Jefferson; Keith Keane; A. A. Lorenz; Leslie A. Osborn; J. T. Petersik; Horace K. Tenney, III; Henry Veit; Chester Wade; Charles Wunsch; and Walter Urben.

In its report to the 1953 session of the House of Delegates, the Division outlined a number of projects which had been launched. Progress reports were presented, and it is gratifying to state to the 1954 House of Delegates that several of these projected activities have been completed and form the major portion of this report. Members of the Division have been asked to meet frequently, as members of various subcommittees, and it is gratifying to note that all who have been asked to serve have done so with both enthusiasm and advance attention directed to the problems placed before them.

While marked strides have been made in providing better facilities for the mentally ill in Wisconsin, there is still a great need for more professional personnel in both state and county institutions. Those in position of leadership in the administration of state and county programs have had too heavy a load placed upon them to permit the development of individualized treatment programs and the projection of case studies which would be highly desirable for future planning. It is hoped that before another report of this Division is presented to the House of Delegates, some of these deficiencies in personnel will be made up and more attention directed to the many programs which have been known to be desirable but which could not be undertaken without more adequate professional personnel.

During the past year the Division has been concerned mainly with a study of the Wisconsin Statutes in relation to commitment of mentally ill persons, the facilities (or lack of facilities) for the disturbed child, and how the field of clinical psychology should be related to psychiatric services in institutions, through welfare agencies, and in private practice. The report which follows summarizes the work of the subcommittees in these separate fields.

### Subcommittee on Clinical Psychologists

E. D. Schwade, chairman; Hans Reese; Saul Pollack; and Chester Wade.

The Committee on Public Policy asked the Division on Nervous and Mental Diseases to study the relationship of clinical psychologists to the field of psychiatric care and to make recommendations concerning what attitude the State Medical Society should take concerning certification, registration, or licensing of this group.

The subcommittee has made an initial study of the problem and is agreed that the clinical psychologist has a role to play in the care of the sick but that his training and experience do not suggest the desirability of licensing or even certification if such certification is merely an opening wedge for an appeal to treat patients without direct supervision of a licensed physician.

With a scarcity of trained psychiatrists and an increasing number of clinics, social service agencies, and other avenues through which persons with emotional disturbances are brought under study, there is a tendency to have non-medical groups assume responsibilities for treatment beyond their capacity as determined by education and training. Superficial treatment is often done, masking serious disturbances which can only respond to skilled psychiatric study. In such instances the public is misled, the patient is retarded in his chance of recovery, and the entire field of psychiatric service is put into an unfavorable light.

It is of concern to the Division on Nervous and Mental Diseases that some state agencies employing psychologists are permitting these individuals to conduct tests and to actually make diagnoses without any medical supervision. It has been reported to the Division that such activities have had resulting traumatic effects upon certain individuals tested; and it is recommended strongly that all state agencies employing psychologists review their practices and make certain that the activities of such individuals are being carried on under proper medical supervision.

Suggesting that clinical psychologists should not assume professional status of the psychiatrist is in no way an attempt to "fence out" a group of persons who have a definite and important role to assume in the treatment of emotionally disturbed persons. There are at present adequate certification groups on the national level so that those persons with superior training as psychologists can present their qualifications to the public. To certify on the state level is, in the opinion of many members of the subcommittee, just one step toward ultimate demands for authority to give treatment to patients independent of medical supervision. It is felt that such a procedure is undesirable from the standpoint of good public health, and it is recommended that any attempts to secure such independent authority be strenuously opposed.

**Subcommittee on Commitment Laws**

Keith Keane, chairman; Walter Urben; J. T. Petersik; Owen Clark; Henry Veit; Roland Jefferson; Michael Kasak; and E. D. Schwade, ex officio.

The work of this subcommittee began in 1953, and a preliminary report was made to the last sesssion of the House of Delegates. Attention at that time was directed mainly to "model codes" of other states and acquiring a general background of the many problems involved with the commitment of mentally ill persons. The County Judges Association was asked to appoint a committee to assist with the development of this project, and special thanks are extended to Judges William R. Curran, Mauston; Harold J. Lamboley, Monroe; Chester H. Christianson, Janesville; George Kroncke, Jr., Madison; and James Levi, Stevens Point, for their assistance. Also, the committee has kept in close touch with Mr. Frank Fosgate of the Department of Public Welfare to correlate the thinking of that department with the work of the subcommittee.

Major attention has been directed to Chapter 51 of the Wisconsin Statutes, and while this report cannot include the specific changes in terminology suggested, it will outline the main points of interest:

*The Epileptic.* The committee feels that it is time to re-evaluate the statutes in relation to the epileptic and change the terminology which reflects archaic relationship between this specific illness and mental disease. It is felt by the committee that the epileptic, as a person suffering from symptoms which may be the result of any one of several diseases and characterized most commonly by an episodic impairment of consciousness and/or interference with motor function, should not be singled out in the statutes for special treatment and, alone among others similarly situated, be classified with the mentally ill, deficient, defective, and infirm. It is felt that if the epileptic with established mental disease is to be committed to a mental hospital, he is to be committed on the basis of his mental affliction and not on the basis of being an epileptic.

While this report concerns itself with specific references to Chapter 51, it is recommended that the Committee on Public Policy sponsor additional legislation which will change the statutes so that no longer will it be a requirement to report epilepsy to the State Board of Health.

*Use of Term "Certification."* It is recommended by the committee that the term "certification" be substituted for the word "commitment" wherever it appears in the statutes. This recommendation is not considered a mere matter of semantics. In 1947 the term "hospital" was substituted for "insane asylum" with lasting and meritorious effect. It is felt by the committee that the same stigma applies to "commitment," and that the use of the word "certification" will have less traumatic impact upon families confronted with problems requiring institutional care.

*Use of Term "Mental Disease" Instead of "Mental Illness."* "Mental illness" is now defined as "insanity" and "mental deficiency" as "feeble-mindedness." These definitions are considered not only antiquated, but inadequate. For example, the psychopathic personality may be dangerous to himself or to others and in need of hospitalization. Yet, there is competent medical psychiatric authority holding that he is neither insane nor feeble-minded. Guided by such medical authority, then, dangerous though such an individual may be, he is not subject to commitment or, if committed, could not be retained legally for necessary custody, care, and treatment.

A general term, medically acceptable and encompassing all persons in need of hospitalization under Chapter 51, was considered advisable. Legal precedent for the use of the term "disease" is found in Section 147.01 (1) (b). Disease is there defined as including "any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts." The term "mental disease" was considered as inclusive and helpful; it is so recommended by the subcommittee.

*Presumption of Incompetency.* Section 51.13 provides that upon the expiration of one year after the granting of a conditional release from a hospital, the patient shall be presumed competent *and his civil rights thereby restored.* This provision and others have given rise in some jurisdiction to the understanding that certification or commitment renders the patient legally incompetent to exercise certain fundamental civil rights.

In point of fact commitment procedures have no relationship to the right to manage one's own property. Commitment procedures are governed by the provisions of Chapter 51, and guardianship proceedings are governed by Chapter 319. As has been pointed out by Frank Fosgate, Esq., of the Wisconsin Department of Public Welfare, "Hospitalization for mental illness *(administrative action by a judge)* is merely a fact which can be shown (among other facts) when there is a petition in *court* to establish a guardian of the person or property on a finding of legal incompetence. At most, hospitalization merely raises a 'rebuttable presumption' as to legal competency."

Accordingly, it is recommended that the following phraseology be used in Section 51.13: *Hospitalization under this chapter, whether by voluntary admission*

*or certification, shall not be deemed an adjudication of legal incompetency in the absence of guardianship, but shall merely raise a rebuttable presumption of incompetency while the patient is under jurisdiction of hospital authorities.*

Minor corrections have been suggested in portions of Chapter 51 to reconcile the phraseology with the definitions of mental disease, certification, and hospitalization. Provision is made to have the examination conducted by the examining physician "at any suitable place," thereby giving the examining physician an opportunity of conducting an examination outside of the courtroom itself.

*Jury Trials.* One important recommendation is that concerning Section 51.03 which provides the right and the procedure to be followed for a trial by jury if demanded by the alleged mentally diseased person. In the opinion of the subcommittee (and approved by Division action), the determination of whether a person is mentally diseased and in need of hospitalization is an administrative proceeding and not a judicial determination. It is admittedly a highly technical, medical problem, which places great responsibility upon the judge and the physicians who must determine the mental status of the person before the court. It is not a matter which can and should be decided by a jury of laymen. However, because of deep-rooted principles in American law concerning the rights of trial by jury, no change in this portion of the statutes is recommended at this time, but when the revisions are presented to the legislature, it is suggested that the views, as outlined, be presented with the suggestion of ultimate change.

*Temporary Detention.* Major attention has been directed to emergency detention and temporary custody of any person who is violent or who threatens violence and who appears irresponsible and dangerous. The application for detention must be made by two persons, one of whom shall be a physician; and to avoid the possibility of a person being detained against his will, without the fact of his detention coming to the attention of the judge, the police officer is required to present the application to the judge within five days. If a judge is not available to issue the order for temporary detention, a court commissioner may do so.

*Temporary Custody.* The law, as it now stands, suggests the use of jails when other facilities approved by the judge are not available. The subcommittee has recommended that this be changed to provide for temporary custody "in a hospital where there are suitable psychiatric facilities and which has been approved by the judge, or, if there is no such hospital, in a place of temporary detention until arrangements can be made for transportation to another facility where psychiatric services are available." If a facility other than a hospital (in practical application, a jail) is used for temporary custody, it is recommended that the statutes require a physician in attendance and that he be called when the patient is admitted.

*Fees.* It is recommended that an adjustment be made by changing the upper limit of $10 to $20 *for participation in the proceedings* (rather than for each day, as the law now reads) plus 10 cents per mile for necessary travel. This change would provide for compensation for the examination of the patient, as well as actual attendance at hearings.

The remaining suggested changes are minor in character and would mostly change phraseology to conform with the definitions suggested by the subcommittee.

In suggesting these changes, it is felt by the Subcommittee on Commitment Laws that if many of the obsolete features of Chapter 51 of the Wisconsin Statutes are changed, a more orderly and medically acceptable procedure for the detention, custody, and examination of mentally diseased persons will be provided. It is hoped that the recommendations of this subcommittee will be acted upon favorably by the House of Delegates, and that the Committee on Public Policy will be authorized to proceed with the preparation of suitable legislation to carry out the recommendations made in this report.

### Subcommittee on the Disturbed Child

Horace K. Tenney, III, chairman; Sara Geiger; Owen Otto; Robert O'Connor; A. A. Lorenz; James Vedder; Robin Smith; W. C. Lewis; L. M. Simonson; and E. D. Schwade, ex officio.

Only one meeting of this committee was held this year with the main purpose to acquire a fuller understanding of what is being done by the Division on Children and Youth of the Department of Public Welfare and its advisory committee. Prior to this meeting the report to the House of Delegates in 1953 had emphasized facilities (or lack of facilities) in Milwaukee and Madison, and it was felt by members of the subcommittee that more attention should be directed to local facilities outside of these two centers. On the basis of studies carried out in Milwaukee among individuals who had severe emotional disturbances but who were not institutionalized, it appeared that the greatest need was not segregation into a special facility but rather fuller use of existing agencies with possibly an intensive short-term treatment until the patient was stabilized to a degree at which he or she could be handled without constant psychiatric supervision.

The obvious need is the development of local short-term treatment facilities in all communities which have direct access to psychiatric and pediatric service. This can and should be developed through local hospitals, and it is urged that support be given to the development of such facilities as a means of meeting many problems on the local level before they become so advanced that institutional care is indicated.

In some areas of the state there is obviously little understanding on the part of judges as to special needs and procedures which should be employed for the handling of children with emotional disturbances. Too often the recommendations of physicians, psychologists, and social workers are treated lightly; and agencies well prepared to correct behavior problems are not given proper jurisdiction and must stand helplessly aside while potential delinquency develops into social problems which ultimately require direct court action. It is recommended that some of the judges known to be most sympathetic with the viewpoints of medicine in this regard be invited to meet with the committee during the ensuing year to see if recommended procedures for commitment of children can be drafted and made available to all courts in Wisconsin.

The further development of Child Guidance Centers offers one avenue through which physicians and social welfare agencies can help meet problems of potential delinquency. The further expansion of this program has been seriously hampered by two factors: (1) no specific direction by a trained individual in the State Board of Health since the resignation of Dr. Eugenia Cameron; and (2) lack of available psychiatric personnel to staff the number of needed centers which might be developed through demonstrations and the enlistment of community support. It is hoped that before another year passes a properly trained successor to Doctor Cameron can be added to the staff of the State Board of Health and that more centers can be set up in urban centers in Wisconsin.

Proper use of the facilities at Sparta is being studied intensively by the Department of Public Welfare, and it is recommended that any utilization of facilities there be provided with full recognition that little can be done effectively with disturbed children without close psychiatric supervision. It is felt by the subcommittee that both short- and long-term treatment might be employed at Sparta, *if there is assurance of proper psychiatric supervision*, and if proper schooling can be provided for those whose residency will extend over a period of time.

The subcommittee is aware of the tremendous possibilities of improved handling of psychiatric problems of children with the creation and operation of the Diagnostic Center. At the same time it is recognized that there is a dire lack of treatment facilities, which lessens the potential effectiveness of the Diagnostic Center. It is felt that consideration should be given to the possibility of utilizing a portion of the facilities for treatment and research (in cooperation with the University of Wisconsin Medical School) until such time as a special treatment center close to the Diagnostic Center and the University can be established. Private general hospitals or other adequate and well-staffed hospitals should be encouraged to enter into the care and treatment of the disturbed child.

While it is commendable that those in charge of Mendota and Winnebago state hospitals and the Milwaukee County Hospital for Mental Diseases are trying as best they can to meet special problems of children with marked psychosis, the subcommittee feels that special attention must be directed to the need for a separate facility (preferably located close to the University of Wisconsin Medical School) for the treatment of selected cases of emotionally disturbed children.

As a corollary of this recommendation, attention is directed to the natural facilities for child care available at both the Northern and Southern hospitals for exceptional children. Both are geared for child care, and both have programs in operation or development which can meet the needs of disturbed children far better than those operated in institutions geared to meet the needs of adult patients. Better use of these facilities is urged with the suggestion that further study be directed to the development of intensified treatment programs on the child level at both localities.

The subcommittee is aware of the fact that many agencies and interested groups are concerned with these same problems. It welcomes the opportunity of keeping in close touch with the Advisory Committee to the Division on Children and Youth of the State Department of Public Welfare, the Legislative Council's Child Welfare Committee, and other groups of a similar nature. Only by directing public attention to the special needs for facilities and programs aimed at the child with emotional disturbances can we hope to reclaim for society the many children who present potential problems of delinquency.

It is hoped that during the ensuing year some of the problems mentioned in this report can be resolved by way of improved facilities, and a greater number of trained persons can be made available for this important phase of medicine and public welfare.

### Recommendations

The Division on Nervous and Mental Diseases recognizes that there are many avenues for work of direct concern to the State Medical Society. The following recommendations are made:

1. While the main work of the Subcommittee on Commitment Laws has been completed, there is need for special attention to those portions of the statutes which concern themselves with the commitment of minors. It is recommended that a separate subcommittee on this subject be created to work in liaison with the Subcommittee on the Disturbed Child.

2. The Subcommittee on the Disturbed Child has pointed out the need to stimulate the development of special facilities in hospitals where pediatric and psychiatric services are available. It is recommended that authority be given to develop this project further through contact with selected county medical societies and medical staffs of hospitals in communities where specialized medical services are available.

3. The need for proper interpretation of present laws seems evident, so that judges will recognize the desirability of utilizing special services for disturbed children, and it is recommended that the Subcommittee on the Disturbed Child meet with selected judges to prepare an interpretive manual on this subject.

4. It is recommended that special study be directed to the further development of treatment programs for the disturbed child (not necessarily with mental disease) at both Northern and Southern hospitals for exceptional children, and possibly a special facility be located close to the University of Wisconsin Medical School and the Diagnostic Center so that study and research in this important phase of pediatrics and psychiatry can be carried on as a part of the medical education of students at the University of Wisconsin.

5. The report of the subcommittee suggests many changes which would strengthen the handling of mentally diseased persons. It is recommended that the report be accepted and that the Committee on Public Policy be authorized to implement the recommendations by way of specific legislative enactments.

6. The report of the Subcommittee on Clinical Psychologists is accepted with the request that if further developments suggest renewed study of this subject, the necessary meetings be held and supplementary reports be made to the Commission on State Departments and the Committee on Public Policy. The conclusion that licensing of clinical psychologists be opposed is supported, and if approved by

the House of Delegates, support of certification of this group will likewise be opposed as unnecessary and as an initial step toward independent treatment of patients, which in the opinion of the State Medical Society is not in the interest of good public health.

7. The need for specific help to physicians in charge of county mental hospitals is recognized, and it is recommended that authority be given the Division on Nervous and Mental Diseases to assist the Director of Mental Hygiene of the Department of Public Welfare and his staff in a manual to be made available to those medical directors of county hospitals desiring it.

8. The American Medical Association's Subcommittee on Alcoholism has suggested state studies on this subject, which suggests the creation of a special subcommittee under the direction of the Division on Nervous and Mental Diseases. It is suggested that such a special study group be created on an *ad hoc* basis to evaluate the problems and give medical guidance where indicated.

## DIVISION ON PUBLIC ASSISTANCE

H. W. Carey, chairman; C. M. Carney; C. A. Olson; L. F. Morneau; E. W. Schacht; and W. K. Simmons.

The Division on Public Assistance is working on the development of a fee schedule that can be the basis of negotiation between welfare departments and county medical societies. The Division is first trying to determine which procedures are used most frequently and on that basis will develop the schedule. Cooperating with it are the State Public Welfare Department, the Division of Public Assistance, and two of the county agencies that have made reports on utilization of procedures within the welfare field. This study will continue with the hope that a report will be made before the next Annual Meeting.

## DIVISION ON REHABILITATION

Ray Piaskoski, chairman; P. J. Collopy; E. P. Roemer; J. G. Beck; and C. C. Gascoigne.

The Division on Rehabilitation has been concerned with the problem of the ability of the Rehabilitation Department to work out a fee schedule which would be agreeable with local physicians and also with federal regulations. The recommendation was made that the Blue Shield "A" fee schedule for the $4,800 income level be adopted by the State Board of Vocational and Adult Education.

The State Medical Society of Wisconsin, through its Veterans Medical Service Agency, has agreed upon a fee schedule with the Veterans Administration in Washington; and, effective July 1, 1954, the surgical schedule of the Blue Shield program was adopted as the fee schedule to be used in the care of veterans.

The State Board of Vocational and Adult Education, at its regular meeting on March 15, 1954, adopted the Blue Shield "A" fee schedule as its schedule for surgical services provided under the LaFollette–Barden Rehabilitation Act.

The Division has under discussion the problem of medical consultation in district and local rehabilitation offices. Terms of appointment and of service of consultants and whether the county medical society should be the organization to suggest the names of prospective consultants are matters now under discussion.

## DIVISION ON SCHOOL HEALTH

E. H. Pawsat, chairman; A. C. Edwards; A. H. Heidner; W. R. Manz; F. J. Mellencamp; and J. R. Schroder.

### School Health Conferences

The major project of the Division on School Health this past year has been the initiation of two highly successful regional Conferences on School Health between school personnel, physicians, dentists, nurses, and representatives of selected lay groups in Eau Claire and Oshkosh. At each of these conferences more than 200 persons were in attendance with major discussions directed to the following topics: "Health Examinations of School Personnel," "Control of Disease," "Emotional Problems of Child Growth," and "Health Aspects of Athletics (Including interscholastic competition on the elementary and junior high school levels)." These conferences proved to be enthusiastically received by all groups represented, and continued emphasis upon the fine public relations for the State Medical Society has prompted the development of an additional conference at Wisconsin State College at Stevens Point on October 20. It is hoped that future conferences can be developed at the colleges at Milwaukee, Superior, and either Platteville or Whitewater during 1955 and 1956.

The Division on School Health is appreciative of the support accorded these conferences through action of the House of Delegates and the Council and pledges close supervision of funds allocated for this purpose so that the maximum benefits can be secured from the funds so invested.

### Bulletin on Health Examinations

The wide use of the bulletin, "School Health Examinations," published by the Committee on School Health of the State Medical Society in 1948 with financial support of the State Board of Health, has suggested need for a reprinting to provide for future distribution. Through the financial support of the State Board of Health and the Department of Public Instruction, such a reprint has been made, and distribution of copies will be made as needs arise.

### Interscholastic Athletic Association

The Division on School Health has been charged with the responsibility of reviewing with Wisconsin Interscholastic Athletic Association officials the medical aspects of this widespread indemnity program. (All other phases of the Wisconsin Interscholastic Athletic Association program are considered by the Commission on Prepaid Plans and do not become a part of this report to the House of Delegates.) A meeting on this subject was held this past year, and special attention was directed to improved methods of acquainting parents with provisions and limitations of the program at a time when actual injury occurs.

The physicians of the state have cooperated generously with this program and have often rendered service without any reimbursement beyond the relatively small amounts which can be paid out in the form of indemnity to the subscriber. Yet, on occasion, there has been resentment that such free service is expected by the parent. To obviate this misunderstanding, the Wisconsin Interscholastic Athletic Association has agreed to furnish all schools with interpretive leaflets to be distributed to parents at the time claim forms are filled out, explaining that the program is not designed to provide "full coverage" and that the attending physician is entitled to charge an additional fee if the services rendered go beyond the limits of payments permitted under the schedule.

The attitude of the Wisconsin Interscholastic Athletic Association board, and particularly Mr. Clifford Fagan, secretary, is one of complete cooperation: and the Division on School Health wishes to give recognition to the fine relationships which have grown up between Wisconsin Interscholastic Athletic Association and the State Medical Society during the past decade. Mr. Fagan and his staff have expressed a desire to have periodic meetings prior to publication of their schedule and medical regulations so that the medical aspects of the program will meet with full approval of the State Medical Society. If physicians have any special problems which they wish discussed in these conferences, they are urged to communicate with the chairman of the Division on School Health.

### Survey on School Health

In cooperation with the State Board of Health the Division on School Health has conducted a comprehensive survey among Wisconsin schools as to the prevailing practices and facilities in reference to school health problems. The results of this survey have been tabulated and will be used as source material in future School Health Conferences.

### Film Available

During this past year the Wisconsin State Board of Health has purchased a fine film entitled "Examining the Well Child," which should be viewed by hospital staff groups and meetings of general practitioners. Its use is urged by the Division on School Health.

### Conclusion

In concluding this report the Division on School Health wishes to express special appreciation for the fine cooperation received from the State Board of Health and the Department of Public Instruction through their respective representatives, Mrs. Catherine Campbell and Mr. Orlo Miller. The work of the Division has been made both pleasant and effective through the close cooperation with these particular individuals and the heads of the departments they represent. It is anticipated that with continued cooperative effort with all groups immediately concerned with the health of the Wisconsin school child, a better health record for our state will be attained; and the physicians of Wisconsin will be accorded the role of leadership which they should rightly assume.

### Recommendations

1. The Conferences on School Health held to date indicate a real need for further development. It is recommended that future meetings be held at selected state colleges as outlined in the report, and that the Audit and Budget Committee be directed to provide for the support of such conferences.

2. Continued cooperation should be encouraged between the Division on School Health and the Wisconsin Interscholastic Athletic Association so that all medical aspects of this important state-wide program will be in line with sound medical practices and in the best interests of the children covered by the program.

## DIVISION ON TUBERCULOSIS AND CHEST DISEASES

H. A. Anderson, chairman; Einar Daniels; Helen Dickie; D. A. Gutheil; F. B. Landis; L. W. Moody; G. C. Owen; A. A. Pleyte; C. M. Yoran; and Milton Feig (representing the State Board of Health).

During the past year two important meetings of this Division have been held, and a variety of matters related to the fields of tuberculosis and chest diseases have been discussed. In outline, the following are some of the high lights of the discussions:

### Evaluation of Mobile Unit Services

It is known that some of the mobile units outside of the immediate direction of the State Board of Health are not being used to a maximum degree, and it has been suggested that an evaluation of

services be made. To date this has not been concluded but is being reported to indicate a need for better coordination and avoidance of duplication of services to certain areas of the state and absence of services to other areas. A threat of curtailment of federal funds indicates the possible discontinuation of mobile unit services through the State Board of Health. The Division views such a development with alarm and recommends that if such an eventuality should seem likely, authority be granted the State Society to contact all Wisconsin congressmen and senators to secure their support for the continuation of such services.

### Possible Correlation of X-ray Units With Lung Cancer Study

Emphasis upon the mobile units for all related chest diseases, rather than for tuberculosis alone, was endorsed by the Division; and recommendations are made that such interested lay groups as the two divisions of the American Cancer Society and the Wisconsin Heart Association emphasize the value of this service to the older age groups and stimulate use of the mobile units when the services are made available to the community.

In relation to mobile unit findings it is important to point out that more physician attention should be directed to those cases classified as "undetermined etiology." The findings of the State Board of Health indicate that among such cases there is great need for intensified study as a high incidence of cancer, heart disease, and other diseases not in any way related to tuberculosis have been revealed. Too often the physician who is confronted with a report of "undetermined etiology" assumes that nothing of significance exists rather than accepting this as a challenge to ferret out the specific ailment which may be suggested.

### Services to Migrant Workers

As an experiment the Wisconsin Anti-Tuberculosis Association is cooperating with the Wisconsin Welfare Council and the physicians of Door County in a program designed to provide intensive screening of migrant workers when they reach Sturgeon Bay. Interpretive material in Spanish has been prepared by a special committee of the Welfare Council giving the worker in simple terms an understanding of what an x-ray is, what it is designed to do, and how it can help the worker without cost to himself or his family. It is hoped that by the next session of the House of Delegates, a more comprehensive report on this subject can be presented.

### Home Treatment of Active Tuberculosis

With the development of new drugs there has been a tendency to treat active tuberculosis outside of the hospital. The Division on Tuberculosis and Chest Diseases wishes to emphasize that *there is no adequate substitute for sanatorium care of patients with active tuberculosis.* Physicians who recommend ambulatory treatment of patients with this disease are doing a disfavor to the patient, his family, and the community. It is a known fact that as a result a very high percentage of persons do not follow the course of therapy indicated with resulting breakdowns in health, exposure of family and community to spread of the disease, and ultimate hospitalization at a point where therapy and recovery are difficult. If a person has been properly treated in a sanatorium and then is referred back to the family physician for ambulatory therapy and close supervision as to use of drugs, with frequent checkups, such a course of patient care is proper and effective. But promiscuous use of drugs as an alternative to institutional care is not sound medicine and is not to be condoned.

As a corollary of this matter, it has been of concern to the Division on Tuberculosis and Chest Diseases that in a few areas there has been a tendency to extend the principles of the free care law (with free service) to all outpatients served. Such practices are not, in the opinion of the Division, far removed from "socialized medicine," and are not in keeping with fundamental principles of medical practice. In some instances free care on an outpatient basis may be justified to meet specific economic situations of the individual, but to apply free care to outpatient services as a general rule is not a policy which should be approved by the State Medical Society. The Division recommends that such policies be not approved.

### Examinations of School Personnel

In 1947 the State Medical Society, in cooperation with many agencies including the State Board of Health, the Department of Public Instruction, and the Wisconsin Education Association, sponsored legislation which permitted school boards to use public funds for payment for examinations of teachers and other employees. Since then many communities have made such examinations compulsory for all new employees and have provided that in many instances the re-examinations (and in some instances the initial examinations) be paid for out of school funds.

A recent survey of all Wisconsin public schools indicates that many communities are now carrying on a satisfactory program. However, some communities have still failed to meet this challenge of public health and to assure that teachers, food handlers, bus drivers, and all other employees in close contact with students are free from tuberculosis. When the survey was made, the Division placed before school boards and school administrators specific recommendations concerning the implementation of this program. The fact that some communities have, as yet, failed to meet these requirements suggests the need for a strengthening of the present law. It is recommended that contacts be made with interested groups to determine to what extent support could be secured for a revision of the present statutes to provide that an examination, including a chest x-ray, be a condition of employment, and that compulsory periodic examinations be made during the course of employment.

### Tuberculosis in Mental Institutions

The Division on Tuberculosis and Chest Diseases of the State Medical Society of Wisconsin has directed its attention to special problems relating to tuberculosis in mental institutions in Wisconsin. It urges that steps be taken to meet this problem through appropriate channels of the state government and its several divisions immediately concerned

with health and public welfare so that patients cared for in all county and state mental institutions will have adequate protection against this contagious disease.

In viewing the problem the Division on Tuberculosis and Chest Diseases is aware that as new methods of treatment are devised, the overall incidence of tuberculosis will be decreased. In any planning to meet the current problem, consideration must be given to this fact and the possible need to use planned facilities for other health functions.

These specific recommendations are offered to assist with the formulation of a program deemed proper and effective by the Division on Tuberculosis and Chest Diseases:

1. *Intensive Screening Program.* Because no adequate concerted effort has been made to evaluate patients in reference to tuberculosis in many county mental institutions, the first need is one of intensive screening and proper evaluation of patients requiring special care. The dual presence of mental afflictions and tuberculosis presents special needs which must be taken into consideration. An intensive screening program suggests specialized personnel under the direction of the Division on Mental Hygiene to classify cases properly and to make appropriate recommendations for care.

2. *Control of Admissions.* While all patients admitted to state institutions are x-rayed to determine the possible presence of tuberculosis, no such precaution is taken, in most instances, when patients are committed direct to county institutions. It is imperative that county judges and physicians signing commitment papers be impressed with the *necessity* of having this service performed at the time of commitment.

3. *Periodic Mass Screening.* Frequent periodic checks of the entire population of mental institutions, both county and state, are highly desirable; and it is recommended that the mobile x-ray facilities of the State Board of Health, Wisconsin Anti-Tuberculosis Association, and local health offices be utilized whenever possible for this purpose. While the specialized problem does not suggest the need for using equipment for this purpose solely, there is need for group planning and coordination of schedules so that the mental institutions will be properly screened at least once per year after the intensive screening program has been completed.

4. *Proper Placement of Treatment Facilities.* While the immediate objective must be proper isolation within the local facility, if feasible, the long-range plan must be the establishment of a special facility *in close proximity to available psychiatric personnel* and availability of medical and surgical facilities related to the treatment of tuberculosis. The members of the Division on Tuberculosis and Chest Diseases feel deeply on this point and recommend that every effort be made to provide a facility close to a medical teaching institution and in close proximity to specialized psychiatric services.

5. *Utilization of Specialized Help in the Local Area.* It is urged that the medical directors of county tuberculosis sanatoria cooperate in every way with county institutions in their area to evaluate patients suspected of having tuberculosis and to assist those in charge of the institution in providing proper isolation and treatment whenever feasible.

6. *Emergency Programs.* Until such time that proper facilities can be provided in close proximity to available psychiatric personnel, there is great need to maintain the Douglas County Sanatorium for the Mentally Ill (Parkland) as a specialized facility for the care of the tuberculous, mentally ill. The present limitations as to charges which can be made for services rendered will not permit the continued operation of this facility so direly needed. It is strongly recommended that state authorities seek out ways in which the institution can be maintained properly and financed adequately.

The Division is pleased to report that increasingly there is a fine working relationship between all public and voluntary agencies concerned with this health problem. The State Medical Society offers an ideal avenue through which all those immediately concerned with the care of the tuberculous patient can interchange ideas and report programs so that maximum efficiency and a minimum of overlapping of activities can be achieved. By close liaison with the University Hospitals, the medical schools, the State Board of Health, the W.A.T.A., and officers of the Trudeau Society, the Division has been able to correlate activities to the benefit of all parties concerned.

### Recommendations

1. County medical societies should work closely with school boards in urging the enactment of school policies to require a health examination (including a chest x-ray, properly interpreted) of all teachers as a condition of initial employment and periodic examinations (including chest x-rays) during the course of employment to give adequate protection to all students.

2. Medical societies and medical auxiliaries should work closely with public health officials and representatives of interested lay groups to stimulate full use of mobile x-ray units by older groups as a means of detecting many related diseases of the chest, other than tuberculosis alone.

3. Attention should be directed in hospital staff meetings and through county medical society meetings to the importance of close examination of all patients who are classified as "undetermined etiology" in reports from mobile unit screenings. By this means it is hoped that many diseases not classified with tuberculosis but existent at the time of the screening test may be uncovered.

4. Attention should be directed through hospital staff meetings and programs of county medical societies to the proper procedures to follow for ambulatory therapy of the patient with tuberculosis and the importance of institutional care during the active stage of the disease.

5. County medical societies should take a more active role in the medical care of patients in mental institutions particularly with reference to proper segregation of cases with active or suspected tuberculosis.

6. The State Medical Society should lend its support to the securing of state funds for the proper operation of the Douglas County Sanatorium for the Mentally Ill (Parkland), as a specialized facility for the care of the tuberculous, mentally ill. At the same time the Department of Public Welfare is urged to explore avenues for the care of selected patients close to Mendota, the University of Wisconsin Med-

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OF PHILADELPHIA

ical School, or in Milwaukee County so that patients can have closer psychiatric supervision than is possible in Douglas County.

## DIVISION ON VISUAL AND HEARING DEFECTS

Maxine Bennett, chairman; John Doolittle; Howard High; E. G. Nadeau; William Randolph; C. G. Reznichek; S. B. Russell; and Edward Zeiss.

For many years the Division on Visual and Hearing Defects (or its predecessor, the Committee on Hearing Defects) has taken an active interest in the development of the hearing conservation program in Wisconsin public schools under the direction of the Bureau for Handicapped Children of the State Department of Public Instruction. From the very start of the program the State Medical Society has assisted in an advisory capacity and has enjoyed the fullest cooperation of Mr. Frank Powell, director of the Bureau for Handicapped Children, and members of his staff.

The Division is pleased to report that the all-state program outlined in its report of 1953 is being carried on with marked success. During this past year 28 counties have been screened on a complete basis, as a part of the once-every-three-year program inaugurated several years ago. In addition, there are a number of urban communities with full-time speech correctionists and public health nurses carrying on a full screening program on a yearly basis with testing being done in alternate grades.

Follow-up cases seen in otologic clinics have always been of concern to the Division, and it is pleased to report that a spot survey conducted by the Bureau for Handicapped Children reveals that 60 to 75 per cent of the patients seen are closely followed up and the recommendations of the otologist carried out. In this regard it is urged that family physicians, receiving reports from an otologist suggesting certain further studies, attempt in every way possible to have the patient carry out the recommendations. If the family physician does not wish to make a direct, personal contact with the family, the public health nurse should be contacted and the responsibility placed with her to contact the family. The effectiveness of the entire program is lost when patients seen at otologic clinics are not followed up as indicated, and the assistance of both physicians and nurses is urged to increase the percentage well above the 70 per cent reported this past year.

The matter of direct referrals to otologists rather than family physicians has been a problem before the Division for many years. It has been generally agreed by members of the Division that in selected cases where otologic services are clearly indicated, the matter of direct referral to an otologist by the Bureau may be warranted; but it has been urged that the Bureau work through the family physician so he is fully aware of the referral and is able to give the family his approval of such a procedure.

During this past year the Division has had its first direct contact with the state agency for the blind associated with the Department of Public Welfare. The services of this agency were outlined to the Division, and attention of all physicians, particularly those in the specialty of eye, ear, nose, and throat, is again directed to the importance of making early referrals when patients are losing their sight and are best candidates for rehabilitation. Referrals, **with the consent of the patient,** are to be made direct to the Division of Public Assistance Services to the Blind, 2385 North Lake Drive, Milwaukee, Wisconsin, so that contacts with the patient can be made at a time when rehabilitation can be employed successfully.

The relationship of physicians to optometrists has received considerable attention by members of the Division. The Section on Ophthalmology and Otolaryngology has a committee which has met with a committee of optometrists to explore programs of mutual concern. Special attention has been directed to the school vision screening program and the development of a program which would permit the patient choice of physician or optometrist but would not permit the optometrist to take an active part in the screening program itself as had been advocated by some optometrists. A suggested school vision screening program has been devised which will be submitted to the Section on Ophthalmology and Otolaryngology and may then be reported to the Division for incorporation with its report to the House next May.

During this past year special attention has been directed to hearing problems related to industry with particular reference to hearing loss and workmen's compensation. The filing of claims based on hearing loss due to industrial exposure has placed a great responsibility upon the medical profession and for the past two years, the State Medical Society has cooperated with the Wisconsin Council of Safety, the Wisconsin Manufacturers Association, and the State Board of Health in the development of Hearing Conservation Clinics at which physicians, management, insurance companies, and other interested parties became better acquainted with methods which should be employed to meet the problem. Concurrently, a subcommittee of the Division was appointed to prepare a "Guide" which might be made available to industry to assist management with the formulation of a hearing conservation program, including audiometric testing and proper record keeping. This "Guide" has been prepared and distributed widely through the agency of the Industrial Hygiene Unit of the State Board of Health and the Wisconsin Manufacturers Association. It has commanded national attention, and copies have been requested from all parts of the country. As a corollary of this program, the State Medical Society has encouraged both Marquette University and the Extension Division of the University of Wisconsin to set up courses of instruction in audiometric testing. Such institutes have been held with marked success and will be repeated as the demand continues.

All members of the State Medical Society engaged in the field of eye, ear, nose, and throat have been contacted for their participation in the hearing conservation program, and a panel of participating physicians has been made available to industry.

The Division on Visual and Hearing Defects is proud to report this important project to the House of Delegates and to state that it has given the State

Medical Society a position of positive leadership which has resulted in good will throughout the state.

### Recommendations

1. Full cooperation should be given the Bureau for Handicapped Children in continued development of the school screening program to reveal hearing defects, and special attention should be directed to referred cases so that the recommendations of the otologist can be carried out to the benefit of the child concerned. If there is any complaint against the services of the otologic clinics, such complaint should be filed with the Division chairman so that the matter can be handled in an orderly fashion.

2. All physicians, confronted with patients losing their sight and in need of rehabilitation, should encourage the patient to accept the help of the Division of Public Assistance Services to the Blind and, with the patient's consent, should see that this agency is informed so that a member of its staff can meet with the patient and start a program of rehabilitation and adjustment before complete loss of sight has resulted in withdrawal and resistance to help for rehabilitation.

3. All physicians in any way associated with industry should acquaint themselves with the recommendations of the special committee which prepared the pamphlet on "Hearing Conservation Programs for Wisconsin Industries," and should assist management in the development of a program which will give workers the optimum protection against hearing loss and assure proper hearing evaluation and record keeping.

## EXCERPTS FROM REPORT OF THE PRESIDENT

**President H. Kent Tenney, Jr.:** It seems to me that it is the function of the retiring president to sort of give the "news behind the news"—to try to explain why we did some of the things we did and to point out some of the things still to be done.

First, as to some of the legislative matters:

The Bricker Amendment was thoroughly discussed by this House last year. It lost by a narrow margin in the Senate but, thank goodness, need not be revived at this time. The dangers it was designed to prevent are still present. It is to be hoped, however, that the wide publicity given them will keep everyone alert enough to protect us.

The administration's reinsurance bill aroused considerable comment in many circles and was actively opposed by the AMA. This opposition brought forth some rather caustic comments from the sponsors of the bill; but, to my mind, our opposition was thoroughly justified.

Mr. Charles A. Wolverton, New Jersey, Chairman of the Committee on Interstate and Foreign Commerce, said he wished the AMA would offer some amendments—amendments which would make the medical aspects of the bill more acceptable—instead of constantly opposing it from the insurance angle. The fact is, the bill had no medical implications as such; and hence no amount of amending could do it any good.

The bill would tend to destory the sound actuarial basis on which insurance plans now stand; and, even though Blue Shield and Blue Cross are nonprofit organizations, they must operate on sound business principles if they are to survive. For the Federal Government to say to the insurance industry, "Go ahead, stick your neck out on poor risks and," to mix metaphors, "if you lose your shirt, we will bail you out," would not only fail to accomplish the stated objectives of the bill but could very conceivably weaken the whole prepaid medical insurance movement.

In fact, it seems to me that a vast Federal subsidy, such as this amounts to, would surely soon take on the political attributes which now characterize the farm subsidies.

Incidentally, the AMA gave active approval to some medical bills; so it was not always an objector.

But I must admit I am also a bit disturbed by our opposition to the administration's proposals.

You may recall that soon after the President delivered his message, in which he gave a rough outline of his plan, the AMA issued a statement saying that it agreed completely with his objectives but that there was not sufficient information on which to base an opinion of the reinsurance plan. Then, when the bill was introduced, the AMA was perfectly sure that its provisions would not achieve these objectives and began saying so.

This is what bothers me: There is a widespread and deep-seated political and sociologic trend toward the participation of government in the health of the people. To deny this trend is to deny a fact of life. To try to stop it is futile.

Let us not forget that we have repeatedly said that we agree with what government is trying to do, but how specific have we been in trying to help government do those things? In certain fields, where we feel that government has a logical and legitimate role to play, I think we can say that our cooperation has been excellent.

For example, let us consider the maternal and infant mortality situation here in Wisconsin. About 17 years ago the State Board of Health, through its Bureau of Maternal and Child Health and with considerable financial support from the Federal Government, started a vigorous educational campaign which was designed to improve our situation in these two closely related fields.

This campaign required and received the cooperation of the State Medical Society, county medical societies, and individual physicians, as well as the people who had and were having babies. At the start of this campaign our maternal mortality rate was 3 per 1,000, accounting for 163 deaths per year; and our infant mortality was 42.2, accounting for 2,308 deaths under one year of age. Now, only 17 years later, maternal mortality has dropped to 0.43, accounting for only 39 deaths, while infant mortality has dropped to 23.4, accounting for 2,069 deaths.

The true significance of these figures can be appreciated only when we realize that the birth rate has gone up tremendously and that if the mortality rate had gone on unabated, we would have lost over 400 mothers and over 3,800 babies. This is truly an outstanding achievement, and one of which we can all be proud.

It is my personal conviction that this fine achievement is in no small measure due to the drive and the financial support supplied by government.

As a final note on this topic, I would like to say that there must be many activities in the whole area of preventive medicine where we could ask for the

government's active participation. Is it not incumbent upon us, then, to point the way and assume some leadership in this regard? I believe it is.

Now to go back to some insurance problems. You have heard and will hear more about our entry into the field of so-called catastrophic insurance. Perhaps you are wondering why we think it wise to venture into this new area. The answer, boiled down to its simplest terms, can be given under these two points:

1. A significant number of families take such a financial beating from major illnesses that they never fully recover. Hence, there is a need for this coverage; and we are meeting our obligation to keep track of and supply the needs.

2. There is a discernible trend on the part of many people to assume the responsibility for the smaller items—say, $25 to $150—but who really want coverage for the severe and protracted illness. In other words, there is a demand for this type of coverage.

Right along this same line, I would like to say that this attitude of assuming responsibility for relatively minor, single-shot expenses is one that we are trying to foster and encourage on as wide a base as possible.

We Americans, by long tradition and usage, seem to have developed an attitude toward insurance companies which might be described as somewhat less than charitable. The attitude that says, "I've paid for insurance on this, so I'm going to collect," is perfectly understandable and perfectly legitimate. But the attitude that permits a little padding here and a little spare there because the insurance companies are such rich so-and-sos is something different.

To a certain extent this attitude seems to permeate even our own profession in its dealings with our own insurance company, Wisconsin Physicians Service. While WPS is certainly in a sound financial condition now, we simply cannot afford to get careless in our use of its funds.

There seems to be a growing feeling in some circles that a large (if not the largest) factor in rising costs of hospital insurance is unnecessary use of hospitals on the part of physicians. The physician admits the patient, and the physician discharges the patient; therefore, *ipso facto*, the physician controls the utilization of hospital insurance.

I do not for a moment minimize the physician's responsibility in all matters pertaining to insurance. It is probably true that some patients could leave the hospital sooner than they do; but, until and unless very convincing evidence is brought forth, I cannot accept the thesis that unnecessary use of hospitals by physicians is the only or even the major cause of the rising costs of hospital insurance.

The problem exists. We must all recognize that fact. If the answer to it is sought by a calm appraisal of all facts obtainable, if all parties concerned will refrain from the easy but futile practice of blaming someone else for the situation, then there is little doubt that a satisfactory solution can slowly be evolved.

Now, a few words about the scientific activities of the Society:

The postgraduate teaching teams covered various areas of the state throughout most of the year, in much the same way as before. The response, at least as measured by attendance, was relatively good, although it is never quite up to what the planners believe the program merits.

The Council on Scientific Work would welcome suggestions from anyone relative to these programs.

This year the Society has participated in several all-day meetings on the general subject, "Physicians and Schools." The attendance at these was made up of teachers, school administrators, nurses, and parents, as well as physicians. Our Committee on School Health took a leading part in planning and conducting these meetings, but it was a joint effort with the State Board of Health; this was another excellent example of the close and harmonious relationship that exists between these two organizations.

It was very gratifying to see so many physicians attend and take an active part in the discussions. Another thing was the obvious fact that school people are viewing health in its broadest sense and not just as the absence of disease. Also, the pleasure (even though mixed with a touch of surprise) that school people felt in finding so many physicians actively interested in school problems was very satisfying. To me personally, the most gratifying experience was to see how broad and how deep an interest all these people showed in the emotional growth and development of children.

It is quite obvious that teachers, parents, and nurses, as well as physicians, are recognizing more and more that a child's intellectual attainments, as well as his social behavior, may be profoundly influenced by his feelings about himself as an individual and about himself in relation to his fellow man.

This brings me to the last point I want to make:

A few years ago it was said that our No. 1 health problem was obesity. That dictum never did impress me very much, and today I am convinced that our No. 1 problem is not obesity but the mental health of the nation. And please remember that mental health is not just the absence of mental illness. Mental health is a positive and dynamic quality of spirit which permits a person to meet the inevitable vicissitudes of life and to survive them without those distortions of the spirit which constitute mental illness. Let us remember, too, that while mental health is very definitely a medical problem, it is not by any means a problem for physicians alone.

Mental health involves every phase of man's life, and thus its preservation is a responsibillty which must be shared by all people who have any dealings in any way with children of all ages.

Let us take, for example, the problem of juvenile delinquency; and, make no mistake about it, it is a problem. Even though sociologists, social service agencies, juvenile courts, police departments, churches, schools, and so on *ad infinitum* have a stake in the problem, it is perfectly obvious that no one group working alone can possibly solve it.

I think it becomes obvious that this whole problem of mental health lies in the field of preventive medicine and that in this field cooperation of spirit and coordination of effort are vital necessities.

Now may I say one final word:

I believe it is impossible to come to the end of a year as president of this Society without a very definite mixture of emotions. One is a feeling of great relief at being relieved of responsibilities that I have felt quite inadequate to meet. Another is a

feeling of gratitude to you for having given me the opportunity to get to know many of my fellow physicians better. The admiration I have developed for their willingness to give so much time and thought to the solution of our common problems is considerable.

Greatest of all, I believe, is the inspiration I have received from watching our staff at work. Time and again, when I have felt that the problem of the moment was almost overwhelming, they have come up with thoughts which indicated that their vision was steadfast on new horizons far beyond and not beclouded by the problem of the moment.

As the most recent demonstration of this, I should tell you that during the past several years as I have been on my way to my own work, I have often taken the opportunity to stop in at the Society headquarters to discuss current problems and future planning. Out of one of these recent discussions has arisen a suggestion that I recommend to the House for its consideration.

The rapidly increasing complexity of medical practice makes it quite apparent that long-range planning as to the integration of services offered in many fields is of considerable importance. To list but a few questions that need answers, we can ask these:

1. If some benefits for dental services are included in our insurance plans, what should be the effect on the dentists' hospital staff privileges?
2. Does the trend toward group and clinic practice make the establishment of clinic pharmacies more or less important?
3. Is the increase in small hospitals, built with Federal funds, outstripping our ability to supply them with necessary ancillary services? In other words, are we sacrificing quality to quantity?
4. Are hospital costs rising at such a suicidal rate that some drastically new approach to the problem is necessary?
5. Are nursing education and practice undergoing changes which are not completely understood by the medical profession and the people at large?
6. Are our educational systems being integrated with medical attitudes toward slow-learning and disturbed children?

These and many other questions are in real need of serious discussion by all groups concerned. In order to implement such discussion, the staff has come up with this suggestion:

Let there be organized regularly recurring, interprofessional institutes on, say, at least a semiannual basis; here the top-ranking people in each field and representatives of various state departments could discuss their problems and work out mutually acceptable programs. This would bring to light many ramifications of plans which might not be anticipated when only one or two groups worked alone.

If, after some thought and discussion, the House thinks the idea has merit, it might be appropriate to refer it to the Council for implementation.

I shall not mention any individuals because to do so would require the full roster of our staff; but I say to you gentlemen in all sincerity that if we as physicians would show the same devotion to the highest principles of our profession that they as a staff show to those same high principles, we could disband our grievance committees tomorrow and start devoting our full time and energies to the many problems which still lie before us.

All of this service, far beyond the call of duty, is carried on under working conditions which can only be described as just short of chaotic. As one threads his perilous way through the mosaic of desk tops which now constitutes our office, he cannot escape the impression that if one girl crosses a "T" at the wrong moment, she may be dotting an "I" on the next girl's notes.

Our new office building, which is well under way at this moment, will not only be a monument to the vision of our staff, but will also be a sanctuary for our unbelievably loyal but much-harassed staff.

## REPORT OF THE PRESIDENT-ELECT

The report of the president-elect, Dr. A. J. McCarey of Green Bay, was published in the November issue of *The Wisconsin Medical Journal.*

His committee appointments were published in the October Medical Forum section of the *Journal* On motion of Dr. A. A. Quisling, Madison, seconded by Dr. G. W. Carlson, Appleton, carried, the committee appointments were approved.

## REPORT OF DR. F. L. WESTON, TREASURER

The following report related only to those operations of the Society which are the direct responsibility of the treasurer.

**CONDENSED STATEMENT OF INCOME AND EXPENSE**
**Year Ended December 31, 1953**

| | | | |
|---|---|---|---|
| **INCOME** | | | |
| **Administrative and General Income** | | | |
| Membership Dues—Current Year | | $166,352.20 | |
| Membership Dues—Prior Years | | 2,479.30 | |
| Other General Income | | 2,069.54 | |
| Total | | | $170,901.04 |
| **Other Income** | | | |
| Public Health Information | | $ 446.35 | |
| Annual Meeting | | 20,076.00 | |
| Clinics and Meetings | | 6,391.60 | |
| Section on Medical History | | 5.00 | |
| Interest Earned | | 540.00 | |
| Amortization of Bond Discount | | 17.00 | |
| Building—Rent from Society Division | | 20,400.00 | |
| Cafeteria | | 7,895.50 | |
| Miscellaneous | | 2,563.90 | |
| Total | | | 58,335.35 |
| TOTAL INCOME | | | $229,236.39 |
| **EXPENSES** | | | |
| **Administrative and General Activities** | | | |
| Executive Staff Salaries | $44,946.83 | | |
| Other Salaries and Wages | 37,963.18 | | |
| Council, Officers, Delegates, and Committees Expense | 14,408.51 | | |
| All Other Administrative and General Expense | 47,379.58 | | |
| Total | | $144,698.10 | |
| **Other Expense** | | | |
| Public Health Information | $15,213.25 | | |
| Annual Meeting | 20,492.97 | | |
| Clinics and Meetings | 7,121.24 | | |
| Interim Appropriations | 7,730.99 | | |
| Amortization of Bond Premiums | 26.73 | | |
| Building | 17,539.87 | | |
| Cafeteria | 9,873.73 | | |
| Total | | 77,998.78 | |
| TOTAL EXPENSE | | | 222,696.88 |
| Excess of Income over Expense | | | $ 6,539.51 |

## DETAILED STATEMENT OF INCOME AND EXPENSE

### Year Ended December 31, 1953

**INCOME**

| | | | |
|---|---|---|---|
| **Administrative and General Activities** | | | |
| Membership Dues—Current | $166,352.20 | | |
| Membership Dues—Delinquent | 2,479.30 | $168,831.50 | |
| Office Service | | 1,204.32 | |
| A.M.A. Collection Service | | 708.51 | |
| Miscellaneous Income | | 156.71 | |
| Total | | | $170,901.04 |
| **Public Health Information** | | | |
| Health Conference Receipts | | | 446.35 |
| **Annual Meeting** | | | |
| Exhibit Rentals | | $ 14,460.00 | |
| Round Table Receipts | | 5,616.00 | |
| Total | | | 20,076.00 |
| **Clinics and Meetings** | | | |
| Industrial Health Clinic | | $ 193.00 | |
| Postgraduate Teaching Clinics | | 6,198.60 | |
| Total | | | 6,391.60 |
| **Other Income** | | | |
| Section on Medical History Dues | | $ 5.00 | |
| Interest Earned | | 540.00 | |
| Amortization of Bond Discount | | 17.00 | |
| Building—Rent from Society Divisions | | 20,400.00 | |
| Cafeteria | | 7,895.50 | |
| Miscellaneous Income | | 2,563.90 | |
| Total | | | 31,421.40 |
| TOTAL INCOME | | | $229,236.39 |

**EXPENSES**

| | | | | |
|---|---|---|---|---|
| **Administrative and General Activities** | | | | |
| President's Travel | $ 750.00 | | | |
| Council, Officers, Delegates, and Committees Expense | 14,408.51 | | | |
| Association Dues | 829.50 | | | |
| Resource and Informational Material | 969.17 | | | |
| Woman's Auxiliary | 920.68 | | | |
| Accounting | 1,741.13 | | | |
| Insurance | 509.85 | | | |
| Rent | 7,680.00 | | | |
| Telephone and Telegraph | 2,125.54 | | | |
| Office Supplies | 5,077.70 | | | |
| Postage and Printing | 5,719.19 | | | |
| Upkeep and Fixtures | 725.03 | | | |
| Depreciation | 2,277.77 | | | |
| Legal Expense | 3,909.66 | | | |
| General Bulletin to Members | 606.69 | | | |
| Blue Book Issue | 2,500.00 | | | |
| Executive Staff Salaries | 44,946.83 | | | |
| Other Salaries and Wages | 37,963.18 | | | |
| Payroll Taxes | 1,501.16 | | | |
| Group Insurance Expense | 926.79 | | | |
| Staff Travel Expense | 7,051.94 | | | |
| Miscellaneous Expense | 1,557.78 | | | |
| Total | | $144,698.10 | | |
| **Public Health Information** | | | | |
| Telephone and Telegraph | $ 416.31 | | | |
| Today's Health | 424.50 | | | |
| Special Bulletins | 572.65 | | | |
| Special Inserts—Wisconsin Medical Journal | 1,200.00 | | | |
| Legislative Counsel | 3,600.00 | | | |
| Press Releases and Services | 431.89 | | | |
| Health Conferences, Exhibits, and Publications | 3,341.02 | | | |
| March of Medicine Expense | 2,341.64 | | | |
| Panel Printing and Postage | 592.00 | | | |
| Salaries and Wages—Other | 877.50 | | | |
| Payroll Taxes | 28.96 | | | |
| Miscellaneous Expenses | 1,386.78 | | | |
| Total | | 15,213.25 | | |
| Totals carried forward | | $159,911.35 | 229,236.39 | |
| Totals brought forward | | $159,911.35 | $229,236,39 | |

**EXPENSES (contd.)**

| | | | |
|---|---|---|---|
| **Annual Meeting** | | | |
| Woman's Auxiliary | $ 500.00 | | |
| Insurance | 10.00 | | |
| Auditorium Rental and Labor | 1,653.00 | | |
| Expenses of Speakers | 1,529.59 | | |
| Publicity and Program Expense | 776.09 | | |
| Union Operation | 203.50 | | |
| Scientific Exhibits | 1,508.52 | | |
| Commercial Exhibits | 1,745.17 | | |
| Stenotype Record | 271.51 | | |
| Round Table Dinner, President's Reception, and Guest Luncheons | 8,071.88 | | |
| Badges | 248.27 | | |
| House of Delegates Expense | 887.41 | | |
| Postage | 300.00 | | |
| Machine Rentals | 185.00 | | |
| Staff Expenses | 1,646.55 | | |
| Miscellaneous Expense | 956.48 | | |
| Total | | 20,492.97 | |
| **Clinics and Meetings** | | | |
| Industrial Health Clinics | $ 228.00 | | |
| Postgraduate Teaching Clinics | 6,293.69 | | |
| Councilor District Meetings | 599.55 | | |
| Total | | 7,121.24 | |
| **Interim Appropriations** | | | |
| Wisconsin Medical Journal | $ 4,200.00 | | |
| Wisconsin Veterans Medical Service Agency | 208.36 | | |
| Student Loan Fund | 1,000.00 | | |
| State Historical Society—Medical History Survey | 1,475.00 | | |
| Other | 847.63 | | |
| Total | | 7,730.99 | |
| **Other Expense** | | | |
| Amortization of Bond Premiums | | 26.73 | |
| **Building** | | | |
| Insurance | $ 522.98 | | |
| Telephone and Telegraph | 2,452.37 | | |
| Depreciation | 3,508.13 | | |
| Salaries and Wages | 5,700.93 | | |
| Heat, Light, Gas, and Water | 1,657.50 | | |
| Repairs | 679.60 | | |
| Supplies | 425.67 | | |
| Property Taxes | 1,308.80 | | |
| Payroll Taxes | 188.18 | | |
| Group Insurance Expense | 102.29 | | |
| Mail Service | 663.57 | | |
| Miscellaneous Expenses | 329.85 | | |
| Total | | 17,539.87 | |
| **Cafeteria** | | | |
| Depreciation | $ 110.68 | | |
| Salaries and Wages | 3,573.04 | | |
| Payroll Taxes | 117.98 | | |
| Group Insurance Expense | 71.29 | | |
| Food Purchases | 4,579.03 | | |
| Beverage Purchases | 1,291.97 | | |
| Miscellaneous | 129.74 | | |
| Total | | 9,873.73 | |
| TOTAL EXPENSES | | | $222,696.88 |
| Excess of Income over Expense | | | $ 6,539.51 |

### COMPARATIVE FINANCIAL STATEMENTS
**December 31, 1953 and 1952**

| ASSETS | December 31, 1953 | | December 31, 1952 | |
|---|---|---|---|---|
| Cash on Hand and in Banks | | $ 29,837.94 | | $ 11,035.42 |
| Due from Divisions of State Medical Society—Current | $ 2,108.01 | | $ 3,577.22 | |
| Due from Student Loan Fund | 203.10 | | 83.32 | |
| Due from SMS Realty Corporation | 433.85 | | ---------- | |
| Accounts Receivable, Physicians, Employees, and Others | 5,595.86 | | 644.94 | |
| Guaranty Deposit | 425.00 | | 425.00 | |
| Total Receivables | | 8,765.82 | | 4,730.48 |
| U. S. Government Bonds—At Net Book Value | | 24,044.26 | | 24,053.99 |
| **Working Capital Advance** | | | | |
| *Wisconsin Medical Journal* | $ 2,398.13 | | $ 1,240.18 | |
| Wisconsin Physicians Service | | | 29,000.00 | |
| Wisconsin Veterans Medical Service Agency | 7,500.00 | | 7,500.00 | |
| Total Advances | | 9,898.13 | | 37,740.18 |
| Land for New Building | $ 18,157.74 | | $ 641.00 | |
| Architect's Fees | 4,820.00 | 22,977.74 | | 641.00 |
| Land—East Gorham Street | $ 31,859.22 | | $ 31,859.22 | |
| Architect's Fees—East Gorham Street | | 31,859.22 | 127.50 | 31,986.72 |
| Office Building | $ 31,969.00 | | $ 31,969.00 | |
| Building Improvements | 19,596.77 | | 18,147.45* | |
| Furniture and Equipment | 32,985.70 | | 31,589.01* | |
| Total | $ 84,551.47 | | $ 81,705.46 | |
| Less: Accumulated Depreciation | 23,930.60 | | 18,819.90* | |
| Total Depreciable Assets—Net | | 60,620.87 | | 62,885.56 |
| Accrued Interest Receivable | | 292.54 | | 292.54 |
| Prepaid Expenses and Deferred Charges | | 995.47 | | 1,297.26 |
| TOTAL ASSETS | | $189,291.99 | | $174,663.15 |
| **LIABILITIES** | | | | |
| Vouchers Payable | $ 11,704.46 | | $ 6,361.96 | |
| Due Divisions of State Medical Society—Current | - - - | | 219.92 | |
| Due American Medical Association | 97.50 | | 79.75 | |
| Prepaid Exhibit Rentals | 7,001.25 | | 4,387.00 | |
| Dues—Suspense | 177.00 | | 323.20 | |
| Income Deferred for 1954 | 2,000.00 | | ---- | |
| Prepaid Membership Dues | ------ | | 1,235.00 | |
| Prepaid Clinic Fees | ---------- | | 1,442.00 | |
| TOTAL LIABILITIES | | $ 20,980.21 | | $ 14,048.83 |
| **NET WORTH** | | | | |
| Surplus—General Fund | $165,883.65 | | $159,349.14* | |
| Net Worth of *Wisconsin Medical Journal* | 2,398.13 | | 1,240.18 | |
| Surplus Reserved for New Building | 25.00 | | 25.00 | |
| Surplus Reserved for Section on Medical History | 5.00 | | ---------- | |
| TOTAL NET WORTH | | $168,311.78 | | $160,614.32 |

### RECONCILIATION OF NET WORTH
**December 31, 1953**

| | | |
|---|---|---|
| Net Worth—December 31, 1952, per Report of Prior Year | | $150,846.78 |
| Adjustment made in Building Improvements, Fixtures and Equipment as of January 1, 1953, in order to restore to the accounts the net book value of items in service on that date, but charged as expense in accordance with accounting system in effect in prior years* | | 9,767.54 |
| Adjusted Net Worth—January 1, 1952, per comparative financial statements | | $160,614.32 |
| **Increases** | | |
| Excess of 1953 General Fund Income over Expenses, including $5.00 relating to the Section on Medical History | $6,539.51 | |
| Increase in 1953 of Net Worth of The Wisconsin Medical Journal | 1,157.95 | |
| Total Increases | | 7,697.46 |
| Net Worth—December 31, 1953 | | $168,311.78 |

*Upon recommendation of the Society's independent certified public accountant all fixtures and equipment of the Society and its divisions were inventoried. An adjustment in the accounts affected was made so that all these assets of the Society on hand and in use might be so reflected. Accounts in the comparative financial statements which differ, at December 31, 1952, from the balances shown in the report for the prior year by reason of this adjustment are indicated with an asterisk. The net effect of this adjustment was, as shown above, to restore to the Society's net worth at January 1, 1953, the net book value on that date of these assets, amounting to $9,767.54.

# REPORT OF THE SECRETARY

The following report of the secretary was published in the *Handbook for Delegates:*

In the days of old the Indian tribes were accustomed to mark a year of significance by a descriptive title such as the year of "many rains." Your secretary is inclined to think it not such a bad idea, for it seems that every year of his experience with the Society has been worthy of special description. For example, 1953 might have been characterized as a year of "important legislation." This year seems to warrant the title of the year of "much building."

### The Office Building

There has been building in the physical sense, for the State Medical Society is well along in the process of completing a structure designed especially to accommodate its many activities and projects. It is history that the Society's office has reached a point where such a building is necessary. The building itself is history; for within it will be preserved records of activities of years past and, in the years future, a documentation of the medical profession in Wisconsin. While not commodious beyond necessity, it will relieve the space strangulation that is now our greatest adversary; and your staff will have room in which to work without disturbing others. The building should produce economy in time and in energy to the point of measurable effect on the efficiency of the staff.

It is not at all possible to discuss the new building of the State Medical Society without marked personal pride. Your staff sees in it the perpetuity of the medical profession and views the medical profession more accurately as a fraternity

*(Continued on page 668)*

*accepta*

# ACH

*record time*

# ROMYCIN*

Hydrochloride
Tetracycline HCl Lederle

ACHROMYCIN, new broad-spectrum antibiotic, has set an unusual record for rapid acceptance by physicians throughout the country. Within a few months of its introduction, ACHROMYCIN is being widely used in private practice, hospitals and clinics. A number of successful clinical tests have now been completed and are being reported.

ACHROMYCIN has true broad-spectrum activity, effective against Gram-positive and Gram-negative organisms, as well as virus-like and mixed infections.

ACHROMYCIN has notable stability, provides prompt diffusion in body tissues and fluids.

ACHROMYCIN has the advantage of minimal side reactions.

LEDERLE LABORATORIES DIVISION AMERICAN Cyanamid COMPANY Pearl River, New York Lederle

*REG. U.S. PAT. OFF.

*(Continued from page 665)*

of men devoted to principles developed and enunciated over the many centuries it has been in existence.

But this year of "much building" is also one of philosophical significance. Some time ago, your secretary observed that the problems of the moment seemed to be of such overwhelming importance that their impact had the effect of preventing planning for the future. There is evidence that the Society is emerging from that highly unsatisfactory situation.

### Prepaid Health Care

The most substantial evidence is the changing attitude toward prepaid health care. The voluntary health care plans continue in their infancy, of course; but it must be clear now that their future role in medical economics is not only conclusive but must be protected. We go then from administration and our current problems to an attitude of appraising the future of a given effort, of judging trends by the experience that we have encountered in our brief existence, and of projecting our place in the sun as we reach maturity. It seems to your secretary that, when he spoke in recent times of the necessity of "resurgence" of interest on the part of the medical profession, he used an inadequate word to describe the matter! It was an appeal not so much for "resurgence" as for "active leadership" in those fields in which leadership can only come from the profession itself. We of your staff, and staff members of any plan, exist to implement leadership. We can suggest, we can indicate the problems, we can advise you of difficulties that may be expected from certain decisions, we can explain your position once taken, and we can argue for it even with others in the medical profession.

But it is you who must lead the way. It is you who must determine what is best for the health of the people.

Here in Wisconsin the State Medical Society has taken a more active part in the affairs of prepaid plans than any other state medical society of which your secretary is aware. Your colleagues, representing Wisconsin prepayment programs, have participated in national meetings and made worth-while contributions. Recognition of that lies in the recent election of your plan chairman, Dr. E. M. Dessloch, as a member of the National Commission of Prepaid Plans.

I believe it may be said that here in Wisconsin physicians are taking the part that is incumbent upon them; but of necessity in the past, it has been only as to their own plan. Now the paths must broaden into wider responsibility.

Employed administrators must not confuse their duties with the responsibilities of those who constitute what amounts to a board of trustees. A board of trustees must never abdicate its authority to its lay administrators.

The truth of these precepts is as unalterable at the national level as it is among state plans. Wisconsin physicians, with a wealth of experience in the role of state-wide medical-economic leadership, need to lend the same stabilizing influence to developments on the national scene. It is an influence that urgently needs support from the medical profession in all parts of the country.

We are in an era of constructive building of policy and programs for the future. And that cannot be "empire building," either in ignorance or in disregard of the fact that prepaid plans are an integral part of the whole structure of health care, which has been created and must ever be guided by the medical profession for the public good.

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### 1954 MEMBERSHIP REPORT AS OF AUGUST 15, 1954

| | | |
|---|---|---|
| Members paying no dues | | 240 |
| (affiliate members | 57 | |
| (military service members | 114 | |
| (honorary members | 8 | |
| (life members | 61 | |
| (total | 240 | |
| Members paying pro rata dues | | 2 |
| (military service members | 2 | |
| (new members | 0 | |
| (total | 2 | |
| Associate members ($10 dues) | | 44 |
| Members in residency training ($3 dues) | | 109 |
| Members paying $60 dues | | 2,774 |
| Total in compliance with all requirements | | 3,169 |
| Total delinquent at date of this report | | 100 |
| Total membership | | 3,269 |

As a supplement to the printed report, Mr. Crownhart distributed a membership report showing a breakdown by types of membership in county-by-county arrangement.

He further introduced the following consultants who regularly serve the Society: Mr. Robert B. L. Murphy, legal counsel, Madison; Mr. Carl A. Tiffany of Carl A. Tiffany & Company, Chicago, the Society's actuaries; Mr. William White, assistant to Mr. Tiffany; Mr. Donald E. Gill and Mr. John White, certified public accountants. He noted that these men are appointed by the Council and are directly responsible to it.

Mr. Crownhart also introduced Mr. Frank W. Kuehl, legal advisor to the Washington office of the American Medical Association.

A supplemental report on necrology was then read; it included the following whose deaths had been reported since the publication of the *Handbook:*

A. G. Benson, Rice Lake
**H. H. Christofferson,** Colby
**Donne F. Gosin,** Green Bay
**G. A. Hipke,** Milwaukee
H. M. Holtz, Beaver Dam
**E. Kraut,** Lancaster
**H. T. Kristjanson,** Milwaukee
**F. W. Mackoy,** Milwaukee
**E. T. Rathert,** Chilton
**L. G. Scheurich,** Tomah
**C. S. Schneider,** Milwaukee
**A. G. Sullivan,** Madison
**F. E. Tryon,** Baraboo
W. R. Whitelaw, Lodi
S. E. Williams, Chippewa Falls.

The House of Delegates rose in silent tribute to these deceased physicians.

## Excerpts from Address of the President of the Woman's Auxiliary

**Mrs. C. R. Pearson, Baraboo:** Because we are a true Auxiliary, never undertaking any project without the consent of our parent organization, we have been very happy to serve in several capacities at your request.

When we learned that tuition pays only 5 per cent of a doctor's education, we were, of course, anxious to have here a rummage sale, there a dance, to raise money to help with the estimated deficit of 19 million dollars in medical schools in 1953. I am proud to report that, whereas last year we donated $5, this year we gave $1,000. Part of this came from the decision your wives made to give memorial cards to the American Medical Education Foundation instead of giving flowers to the families of the deceased.

When asked, we have served on your civil defense project, helping with mobile units, setting up rosters of nurses who would be available in case of emergency, and bringing in speakers to inform the public.

Auxiliaries visited have been told of legislation pending before Congress relating to any phase of public health, the doctors' stand, and why.

At the request of the American Medical Association, we continue to put *Today's Health* where the public may read it. Here you can help by giving your subscription to your wife; for your magazine should be placed not only in factories, libraries, schools, and dentists' offices, but in every doctor's office.

Your Society asked us to obtain your histories so that we may have autobiographies, as well as biographies, in the archives of the State Historical Society. Again, we ask your cooperation.

At your request, we have aided the work of the mental health units in the state. One new group equipped the children's room in their new mental health clinic; another managed a house-to-house drive. Many have given gifts to local mental hospitals; and all have endeavored to learn more about the equipment, setup, and possible gaps where help might be given in their local institutions.

Doctors' wives in 12 more counties have joined the Auxiliary since last fall. Our thanks to the Douglas County Medical Society for pioneering, as was suggested to you last year, and including their wives' dues with their own. It is our sincere hope that many of you will follow their example.

Your wives have lived up to what is expected of them with many hours of service to the Red Cross Blood Bank; the tuberculosis mobile units; cancer, March of Dimes, Heart, and Easter Seal drives. This year for the first time we donated to Camp Wawbeek, and we have given to many hospitals and visiting nurse associations.

Without a doubt the *pièce de résistance* of the Auxiliary's work these past few years has been nurse recruitment. Through speeches at schools, movies, and hospital tours, we continue to teach high school girls (and a few boys) about the invaluable service they could render. This past year 23 scholarships and loans, in the amount of $3,765, have been offered. Another state scholarship of $100 was presented; this was donated by small auxiliaries who were unable to offer a scholarship of their own.

Future Nurse Clubs have been organized so that high school students may learn, before they enter, whether this is the right field for them. Twelve of these clubs have been organized by your Auxiliary. We continue to assist the State Department of Nursing with its Speakers Bureau and through distribution of material for nursing brochures.

Thanks to you, we have an outstanding paper, *The Badger Doctor's Wife*, we can put on excellent conventions, and we can always be assured of perfect secretarial help. Do call on us whenever we can be of any further help to you.

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Mrs. Victor Falk of Edgerton, president-elect of the Auxiliary, was introduced by Speaker Simenstad.

## Introduction of Student AMA Members

Speaker Simenstad called upon two observers from the Student American Medical Association, who rose as they were introduced. They were Mr. Wayne Munson of Madison, president of the Wisconsin Student AMA, and Mr. Robert G. Brault, Milwaukee, representing the Marquette Student AMA.

## Excerpts from Remarks of State Health Officer

**Dr. Carl N. Neupert:** To me and to the Board of Health it means more than I can tell you that you and the 3,000 physicians you represent make it possible, to so large an extent, to go forward in promoting the "life and health of citizens," the Board's charge of responsibility as set forth in our own state law. May I remind you that a rural physician, with the support of the State Medical Society, was instrumental in the enactment of that law creating the State Board of Health in 1876.

You, as a body, along with your colleagues in daily practice, have been responsible, more than any other group of citizens, for the very creditable advances in health our people enjoy. You deliver 99.9 per cent of the babies in Wisconsin, giving their mothers outstanding care during pregnancy and at delivery. Look back only 15 years to 1939, when there were 153 mothers lost in childbirth, as compared with an average over the last five years of under 45. During that time total live births have gone up from less than 60,000 to 88,000.

In tuberculosis control a combination of finding undiscovered cases and, especially, development of newer drugs and advanced lung surgery has contributed to the continued downward trend in tuberculosis deaths. The Board heartily concurs with the position of our colleagues in the Tuberculosis Society that there are hazards and disappointments inherent in the home treatment of tuberculosis.

The success story in health achievement in Wisconsin is a very fine one in so far as we have been able to go, but we still have much more to do in reducing cancer deaths; in reducing the appalling accident toll; in improving nutrition, including the overweight problem; and in mental health and other fields. Prematurity, neonatal and infant deaths need our best combined efforts.

Broader than just sanitation and communicable disease control, the State Board of Health has earned

your confidence and that of the people of this state in its concepts that basic responsibility for health is that of the individual or his family and that government's role is that of doing what individuals or groups cannot do for themselves or cannot do as well for themselves.

The role of the State Board of Health, therefore, is one of promoting healthful living and preventing illness in the areas of activity in which it is particularly able.

Expenditures of tax funds for public assistance, aid to dependent children, and old-age assistance are on the increase. To an appreciable extent health failure is a contributing factor to the need for that assistance. That portion will continue to grow except as preventive measures are applied.

Preventing of health neglect is economically sound. Certain portions of it can be done best by an official (government) agency.

## Supplementary Report on the Maternal Mortality Study

Dr. T. A. Leonard, Madison, presented a progress report on the Wisconsin Maternal Mortality Survey. This report was published in the November issue of *The Wisconsin Medical Journal.*

## Supplementary Report of Commission on Prepaid Plans

Secretary Crownhart orally presented a supplementary report of the Commission on Prepaid Plans which had been reviewed by the Commission itself and by the Council the preceding day.

In opening his remarks Mr. Crownhart traced some of the history in prepaid insurance, stating that some few years ago advice was received from national figures in the prepaid field that the development of some form of coordination between the various Blue Shield plans of the country was becoming inevitable. Because of enrollment problems on so-called national accounts, it would become necessary that negotiations be conducted with one agency and that Blue Shield plans, about 78 of them today, would have to delegate to a national agency negotiations involving national accounts, which at that time were understood to be those wherein the employees resided in the area served by more than one Blue Shield plan.

For example, a large automobile manufacturing concern might have employees in Wisconsin, Michigan, Minnesota, Iowa, and elsewhere. Being interested in Blue Shield, nevertheless it wanted to buy certain administrative details from one organization. The theory was that the funds so received would be funneled out to each plan, which would maintain its own autonomy in its area; and the money that each plan would receive would be in line with the plan's fee schedule, its income level, and its own local experience.

After controversy within Blue Shield and consideration by the American Medical Association, the conclusion was reached that Blue Shield, being the doctor's plan, should retain its own identity and that such national organizations as might be developed to meet these practical problems be developed in such manner that Blue Shield would be represented by its own group and Blue Cross by its own group.

The eventual evolution led to the creation of two regular types of insurance companies. One is known as Health Service, Incorporated, which is an insurance company wholly owned within the various devices of Blue Cross, which is finally supervised and directed by the American Medical Association. The second company is called Medical Indemnity of America, which is licensed in about five states.

Medical Indemnity of America is an insurance company which is wholly owned by the Blue Shield National Association. Each plan contributes in varying amounts to its capital structure; and the ultimate control rests in the Blue Shield Commission, which is the board of directors or board of trustees of the trade association of 78 Blue Shield plans throughout the country.

The Blue Shield Commission is elected in such manner that on that Commission there are both doctors and laymen in fields of executive capacity within their own districts. Areas of the country have been divided; and the plans in this area, known as the Tenth District, are entitled to elect a layman from among the executive directors and to elect a physician from among the physicians directing activities within the plan.

The director of Iowa Medical Service, Mr. W. H. Sherin, is the layman; and Dr. E. M. Dessloch, chairman of the Commission on Prepaid Plans, Wisconsin, is the physician member of the Tenth District.

While the two insurance companies above described have two identities in the technical sense of the term, as a practical matter they stand almost as though merged. Each has agreed to reinsure 50 per cent of the risks acquired by the other; and that brings them together under a joint operating agreement in which it is further provided that administrative affairs of the national company shall be handled by a single executive staff, supervised by a joint operating committee of six individuals, three of whom are associated with Blue Cross in various states and three of whom are associated with Blue Shield, all on an executive basis.

A law which is setting the pattern for the problem today was enacted during the past Congressional session. That law permits the government to participate in the payment of a portion of insurance premiums for Federal employees. It is already effective as to life insurance. It is understood that further legislation will be negotiated, and representatives of national Blue Shield have been in conference with the membership of the Federal Civil Service Commission to negotiate into law or into regulation a pattern of surgical-medical protection which apparently could only be provided by Blue Shield.

It is understood that negotiations with the Federal Civil Service Commission involve full payment to those employees without dependents whose annual income is $4,000 or less; and, for those with families, it would apply to annual earnings from the Federal Government of $5,000 a year or less.

It is estimated that under that device about 85 per cent of Federal employees in all areas of the

nation would have the benefit of full payment, which means that the plans participating would commit their physicians to the principle of full payment at an income level differing from that which has been determined as best for Wisconsin citizens outside of Milwaukee County.

Mr. Crownhart then pointed out that a number of things might be negotiated by one in the position of negotiating on behalf of the Federal Government and its employees. For example, he might be concerned with the topic of free choice of physician and with recognition of ancillary services in the field of treating the sick, not performed by licensed physicians and surgeons. He might find the necessity of developing a uniform fee schedule and might make the suggestion that the full payment level be increased. He might urge that the program be extended to other fields of federal interest, such as public welfare cases, perhaps on a different premium structure. He might go into conference with the Veterans Administration, suggesting Blue Shield be extended on a national basis to the care of non-service-connected cases. He might find that by hiring help he could obtain some kinds of medical services cheaper than by obtaining them under the insurance principle, as, for example, pathological examinations provided through government laboratories rather than by the individual practitioner. He might determine upon certain limitations with reference to medication or might make a suggestion as to the necessity of an operation or, when certain operations are to be performed, suggest that perhaps they be done by a panel of physicians whose competence is attested for certain specific or specialized procedures.

Mr. Crownhart stated next that all this was a development not fully related until very recently but that certainly there were important implications involved to be more fully determined in the near future. He had been directed to attend a special conference of Blue Shield plans to be held on these problems in Chicago on October 11 and 12.

The recommendation was made by the Commission and by the Council of the Society that this report be referred to the Reference Committee on Resolutions and that, because much of the problem was uncertain, the reference committee recommend to the House of Delegates that the subject be returned to the Council, under its authority to act as the executive body of the House between its sessions.

## Recess

On motion of Dr. E. C. Cary, Reedsville, severally seconded, and carried, the House of Delegates recessed this session at 11:50 a.m. until 2:30 p.m.

## Call to Order

The recessed meeting of the first session of the House of Delegates reconvened at 2:40 p.m., Dr. L. O. Simenstad, Speaker of the House, presiding.

## Further Supplementary Report of the Commission on Prepaid Plans

Dr. H. Kent Tenney, president of the Society, then presented the following supplementary report of the Commission on Prepaid Plans:

### INTRODUCTION

The Commission on Prepaid Plans believes it timely to report in fuller detail its future planning and recommendations with reference to Blue Shield of Wisconsin.

Prepayment plans have emerged from their developmental days and from their period of mushrooming growth. Their public acceptance has been little short of phenomenal. Their progress is now challenged by certain inadequacies and by administrative problems.

What are some of these, and what may be done about them? The Commission emphasizes that it speaks only for itself and only for those parts of the state which are served by Blue Shield of Wisconsin.

### NON-GROUP ENROLLMENT

There is obvious need to provide mechanisms of non-group or individual enrollment which are adapted to the less populous areas of the state. Such "non-group" enrollment is today hedged in with too many "ifs." To "protect" all subscribers of the "Blue" plans, each non-group applicant is carefully screened in an effort to assure that he is not buying the contract to pay for planned care in the early future. But this screening may be both harsh and unrealistic in light of other considerations.

With careful planning and realistic underwriting there seems to be no reason why individual subscribers cannot be so enrolled as to conform to the law of averages quite as well as a group of subscribers with a common employer.

#### Older Ages to be Included

The Commission proposes in the early future to redesign the enrollment requirements for individuals, as distinguished from group subscribers, so that the older age element may be insured, protective riders as to pre-existing conditions terminated rather than continued for the life of the contract, and unnecessarily broad medical exclusions narrowed to the actual condition involved. In partial fulfillment of the obligations of the profession to the health of the general public, the Commission feels it essential not only to protect its plan, but also to design that plan in a way which will afford genuine basic protection to all elements which need and wish to purchase it. The recent addition of maternity benefits to the non-group contract is a concrete step in this direction.

#### Northwest Wisconsin Experiment

One hears much talk today about the intrinsic superiority of the so-called "non-profit plans." Time alone will furnish the answer; but, no matter what their intrinsic superiority may be, such efforts will have been largely in vain until the plans have developed practical, effective, and inexpensive mech-

anisms for making coverage available to those large segments of the public which want such protection but which are employed in small groups, or which do not belong to "groups," as that word is used in the insurance world.

In recognition of this basic problem of getting its plan into the hands of those segments of the public which do not now have it, the Commission on Prepaid Plans recently launched in certain northwestern counties of this state an experimental program in an effort to determine how non-group policies can be successfully offered and sold in a nonindustrial area. This experiment is part of the principal report made to the House as reported in the *Handbook for Delegates.*

### Non-Group Monthly Billing

Blue Shield has long been urged upon the public as a mechanism of regular budgeting. In the non-group field, Blue Shield now bills its subscribers quarterly. That practice does not provide the purchaser with the same opportunity of budgeting as is available to those who purchase a group contract on a monthly billing basis.

The Commission believes that the non-group purchaser should have the option, at least, of being billed monthly rather than quarterly. The lower administrative expense in quarterly or even less frequent billing can be effected through somewhat lower rates when such billing cycles are selected. Monthly billing has been successfully adopted in other fields of insurance and is receiving increased attention in the national conferences of Blue Shield and Blue Cross.

The "best" contracts offered by Blue Shield and Blue Cross to non-group applicants now cost a total of $12.15 monthly. A quarterly billing of $36.45 is a deterrent to retention of the program by many individuals, particularly those who have not received any benefits under their contracts.

## SALE OF BROADENED GROUP BENEFITS

Blue Shield of Wisconsin can be proud of its record of not having increased the cost of its program except on the one occasion when its benefits were increased. Blue Shield is concerned that *administrative* costs be held to a minimum so that a maximum part of the premium dollar may be available for subscriber *benefits.*

It should be emphasized that the broadening of benefits does not necessarily increase administrative costs in direct proportion. For example, the basic program of Blue Shield provides surgical benefits beginning with the fourteenth day of life. By special rider, and at negligible added cost, the purchaser may secure surgical coverage from the date of birth.

All but a small portion of the income from this rider is available for the payment of that benefit.

These and other riders extending group plan benefits were developed in the past two years and reported in part to the House in 1953 as desirable extensions of coverage. Their purchase by contract holders has not progressed satisfactorily to date. The Commission's staff has been directed to give attention to this subject. To that end a small number of employees will be added whose primary purpose will be to improve existing contracts rather than to write new ones.

## DEVELOPMENT OF DEDUCTIBLE FEATURE

On its economic side prepaid surgical and medical care is not a collection device for physicians as much as it is a budgeting device for subscribers. That being true, the Commission thinks it important to re-evaluate certain basic premises at reasonable intervals so as to determine whether its Blue Shield program is as effective a budgeting device as it might be. In the course of such evaluation it has become apparent that small, infrequent charges for routine professional services are not really burdensome to the subscriber. In partial recognition of this fact the Blue Shield plan has not included office or home medical calls but has limited medical care to hospitalized cases since the latter are certain to include the more serious and sustained illnesses. On the other hand home and office surgery is included since the place where it is performed is often a matter of choice.

Blue Shield has determined during the past two years that it costs about $3 to administer an average claim. Many of the minor claims require more correspondence and administrative time than larger ones because of the difficulty of determining just what services the physician performed. If, for example, the professional charge is $3 (and a number of them are), the premium must be enough to pay $3 for the benefit and $3 for administering the claim. This is a total of $6 which has to be charged for a $3 benefit. While the example is an extreme one, it illustrates the point that the coverage of minor claims is not good economics or good sense.

### First or Last Dollar Coverage?

The general public has often been told in advertising and otherwise that the first dollar should be covered for illness care. It is the Commission's belief that if the plans persist in this view, it is because they unwittingly stress the collection device to physicians rather than the health budgeting service the plans are designed to render to the public. It is believed that it would be a serious error for the voluntary, prepaid health plans to neglect their obligation to educate the public to the consequences of trying to cover *first* dollars. It is much more important to cover the *last* dollars. The profession in this state has tried to do this, first, through its full payment principle and, more recently, through the development of a major illness expense policy. It acknowledges imperfections in both efforts, but it is working toward the goal of covering truly burdensome health costs.

### How Much Can Purchaser Afford?

There has been a consistently mounting total cost to the subscriber who carries the Blue Shield–Blue Cross programs. The point may well come, if it has not already been reached, where the buyer refuses to pay more for his basic protection. There are at least three regrettable consequences of such refusal. The first is that a number of the healthier risks tend to drop the plan and become self-insurers although they are needed to give the plan actuarial balance.

Second, the feeling that the total cost is too high encourages some groups to switch their programs from Blue Shield to an inferior contract which may be available for substantially less money. Health and accident coverage is still in its early stages of development. Those who develop and administer these programs do not know many of the answers. The general public is sometimes understandably less interested in the technical differences between contract benefits than it is in reducing or holding dollar outlay to the minimum. It will be many years before the general public can be educated to distinguish qualitatively between a good and a poor program. All too often has it been impressed with a few highly-touted items which diverted attention from the limitations of the balance of a particular surgical-medical contract.

A third consequence of a program which is too expensive is the resulting unwillingness of the public to buy (1) all the elements of the contract, or (2) benefits proportionate to income, or (3) major illness protection. People tend to assign a certain dollar limit to various segments of their budget; and when that limit is reached, they resist going beyond it.

### Deductible Contracts Advisable

In light of the above the Commission is beginning studies into the feasibility of offering its contracts with varying deductible amounts. The purpose and the mechanical device are analogous to the deductible feature of an automobile policy. One group might want the first $15 of a particular benefit deducted. Another might want $25, and still others $50 or $100.

The offering of any of the above alternatives, as such, does not pose special difficulties. The problem arises in trying to preserve the principle of full payment. To illustrate, if a particular group has a $50 deductible provision, and a subscriber carrying the "B" schedule has an appendectomy performed by a participating physician, is the latter limited to a total of $100, which may be further reduced by the collection hazard on the $50 due directly from the subscriber?

### Complicates Full Payment

A major consideration for that fee in the present program is that the physician does not have the expense of collection. Yet, he will have to look to the subscriber for the *first $50* in this particular case since he will receive only the *last $50* from Blue Shield. There is little point in developing a deductible device which will tear down the service or full payment principle which the medical profession of this state has built with much care and effort over a period of years. The full implications of the deductible device for the general public, the physician, and Blue Shield must be carefully considered before it is put into operation.

### Catastrophic Protection Aided

If that device can be worked out with fairness to all concerned, it should mean a substantial reduction in contract rates because of the saving in benefits payable and in administrative costs. It will release funds to a contract holder. With these he can pay part of the costs of major illness expenses which are genuinely burdensome. Today those funds are used on an uneconomic basis to pay the minor costs of illness care which are not burdensome. Blue Shield will be relieved of the necessity of administering small claims and should be able to handle the larger claims at reduced cost.

## WAIVER OF PREMIUMS

Several years ago the Commission gave preliminary consideration to the development of a provision which would keep a contract in force when the subscriber was unable to make premium payments because of physical or other disability. As everyone who carries ordinary life insurance knows, it is possible, after reserves have been built up, for premiums to be paid out of such reserves for a length of time proportionate to their size. Everyone familiar with life or time-loss policies is also aware that a premium-waiver rider can be purchased which will apply where the insured suffers total disability.

### Unemployment and Disability

The Commission is interested in determining whether a means might not be developed in the Blue Shield plan to cover (1) periods of unemployment or (2) loss of wages caused by disability. The Commission was unable to find that anything had been done in this direction when it first concerned itself with the problem. There has recently been some acknowledgement of the problem and its possibilities, but nothing specific has been developed to date as far as the Commission is aware.

It is believed important to explore this subject in an effort to determine the feasibility of offering this opportunity on the condition that benefits be available only during a designated period of involuntary unemployment or income loss from disability. It would probably not be practical administratively to pay any such benefit during partial unemployment because of the high administrative costs of investigation.

The Commission is of the present opinion that such a contract benefit should prove extremely valuable during a period of unemployment or disability when the employee-subscriber might otherwise cancel his Blue Shield protection at the very time he could least afford to lose it.

It might also provide stability to the Blue Shield plans. Of the approximately 80 in this country, none has been tested in an economic depression. Some few have gone through short-lived periods of recession or adjustment of local or regional character, but these are not to be confused with a general depression. It is certain that Blue Shield of Wisconsin, which did not begin active operations until the spring of 1947, has not thus far experienced a general economic recession. It is, therefore, impossible to foretell the effect of such an economic setback on the plan. Consistent with its responsibilities to subscribers and participating physicians, the Commission feels the obligation of developing any device or technic which may assist the subscriber and the plan in weathering economic storms.

### STUDY OF AREA PREMIUMS

There are two discernible trends in the matter of benefits. One is that there can and should be uniformity dollarwise throughout the state. The other is that there be some area or regional adjustment of benefits. Each trend is reflected in the rates or premiums charged.

Some commercial insurance companies have already recognized this problem and now charge premiums which are adjusted by areas to reflect experience and other cost factors in such areas.

While a uniform premium and uniform benefits are simpler to administer, the more important question is whether such uniformity is in the best interests of the public and the profession, irrespective of area variations. All physicians know that there are measurable variations in charges for certain professional services between heavily and lightly populated areas.

The Commission is well aware that much as this problem may need study, it should not be oversimplified. Again, its implications for the principle of full payment must be fully considered. There is certainly no real advantage in unsettling one part of a plan in order to establish another. Such loss of balance is not only undesirable but could have an over-all adverse effect if permitted to continue unchecked.

### PUBLIC CONFERENCES RECOMMENDED

To assist in the solution of these and other problems, it seems increasingly desirable that those directly concerned in the administration of voluntary health insurance plans have the advantage of expressions of views by various segments of the purchasing public. Such expressions could include constructive evaluation and criticism of the present program, plus recommendations for its further improvement. The views of the housewife, as well as those of her husband, should be sought. The farmer should be heard from as well as the laborer. The educator, the executive, the government employee, and the several professions could undoubtedly all make valuable contributions by way of reaction, evaluation, and suggestion.

#### Grass Roots Participation

The Commission has considered advocating a state-wide public conference. But these seldom "fill the bill." What is needed is grass roots participation. The Commission believes that possibly four or more area conferences should be arranged during the coming year. It does not propose to handle the physical arrangements or the program. As a matter of fact, it believes that any participation by Blue Shield in the actual program should be, at the most, nominal in character. If it is the advice and the problems of the individual consumer which are desired, then it is the consumer who should have the opportunity to be heard. The Commission is well aware that there are always some malcontents and rabble rousers who take advantage of such public hearings, but these are calculated risks. As risks, they are too unimportant to delay the major objective of such conferences. The Commission proposes to contribute a sufficient sum to the University of Wisconsin to enable it to organize such a series of conferences and provide them with the constructive programming to which they are entitled.

### CONCLUSION

The report of the past year's activities of the Commission was first submitted to the Council and was reported in the *Handbook for Delegates*. It is essentially concerned with certain facts of the operation of Blue Shield of Wisconsin. The purpose of this supplementary report is to indicate some of the many unresolved problems of the Blue Shield plan and to suggest possible ways and means of solving them. It is hoped that through careful reading of the two reports it will be possible for the medical profession of this state to discern some of the long-range objectives and planning of the Commission in the prepayment surgical-medical care field.

While a voluntary prepaid health plan is readily distinguishable from preventive or public health medicine, it is equally one of the responsibilities of the medical profession. It can contribute substantially to the welfare of the citizens of the state and can serve at the same time as a means of preserving the independence of the citizen in providing the economic basis for his own health care.

It has recently been said that it is the physician who will "completely" determine the future of voluntary prepaid medical care. It might be more accurate to state that the physician will play the leading, rather than the exclusive, role in determining the future of voluntary health insurance. The medical profession can do so only by continuing to assume its rightful leadership and by joining together all those elements of our society which share its philosophy.

## Reference of Reports

Speaker Simenstad announced referral of reports to the following committees:

*To the Reference Committee on Reports of Officers:* General report of the Council; statement on scientific foundation; reports of the president, president-elect, treasurer, secretary, and AMA delegates.

*To the Reference Committee on Reports of Standing Committees:* Reports of the Committees on Blood Banks, Civil Defense, Military Medical Service, Cancer, and Public Policy; reports of the Council on Medical Service; Council on Scientific Work; Veterans Agency Committee; and Commission on State Departments; supplementary report on maternal mortality; and statement on future meetings.

*To the Reference Committee on Resolutions and Amendments to the Constitution and By-Laws:* Resolutions on Uniform Expiration Date, Delegate Term, Length of Resident Membership, New Date for Delegate Apportionment, and Annual Meeting of Council; report of Grievance Committee; resolutions on Section on Urology and on Section on Public Health; report of Commission on Prepaid Plans; supplementary reports by Doctor Tenney and Mr. Crownhart; resolution on Advertising of Alcoholic Beverages; Dues for 1955; Resolutions on *Today's Health*, on Governor's Conference on Highway Safety, and on Nursing Education.

Announcement was made of the time and place of the reference committee meetings.

## Committee on Nominations Selected

Following a councilor district caucus of delegates, on motion of Dr. E. D. Sorenson, Elkhorn, seconded by Dr. J. W. Prentice, Ashland, carried, the following delegates were approved as members of the Nominating Committee.

| *District* | *Nominee* |
|---|---|
| 1 | F. A. Gruesen, Fort Atkinson |
| 2 | L. E. Fazen, Jr., Racine |
| 3 | J. H. Houghton, Wisconsin Dells |
| 4 | O. E. Satter, Prairie du Chien |
| 5 | E. C. Cary, Reedsville |
| 6 | H. J. Kief, Fond du Lac |
| 7 | R. L. MacCornack, Sr., Whitehall |
| 8 | C. E. Koepp, Marinette |
| 9 | M. V. Overman, Neillsville |
| 10 | W. C. Henske, Chippewa Falls |
| 11 | Charles W. Giesen, Superior |
| 12 | J. A. Enright, Milwaukee |
| 13 | C. E. Zellmer, Antigo |

## Adjournment

The first session of the House of Delegates adjourned at 3:20 p.m.

# SECOND SESSION

## Tuesday, October 5, 1954

The second session of the House of Delegates convened at 7:30 p.m., Dr. L. O. Simenstad, Speaker of the House, presiding.

## Report of Committee on Credentials

The Committee on Credentials verified the registration of 69 delegates and six alternate delegates entitled to vote at this session of the House of Delegates. In addition, eight alternate delegates and 10 councilors registered their attendance.

On motion of Dr. J. W. Fons, Milwaukee, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll of delegates and alternate delegates totaling 75 was accepted as the official roll of this session of the House, to stand for the entire session.

## Report of Reference Committees

## REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS

This reference committee was composed of Drs. S. A. Morton, Milwaukee, chairman; W. D. Stovall, Jr., Brodhead; H. J. Kief, Fond du Lac; E. W. Humke, Chilton; and R. A. Thayer, Beloit. Doctor Morton presented the report.

### REPORT OF THE PRESIDENT

Dr. H. Kent Tenney, Jr., Madison, was commended highly for closely following the affairs of the Society and of medicine nationally during his term of office. The reference committee recommended that Doctor Tenney's recommendation with respect to organization of regular interprofessional institutes be referred to the Council for implementation at the earliest possible time.

On motion of Doctor Morton, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, this section of the report was accepted.

### REPORT OF THE PRESIDENT-ELECT

Dr. A. J. McCarey, Green Bay, was commended for his inspiring address; and the reference committee concurred with his desire to re-emphasize the importance of closely adhering to the essential philosophy of the care of the sick as a task of love and mercy. It also approved his counsel that physicians participate more actively in local civic enterprises and in such affairs as the Blue Shield movement, the American Medical Education Foundation, and the Student Loan Fund.

On motion of Doctor Morton, seconded by Dr. R. L. MacCornack, Sr., Whitehall, carried, this section of the report was accepted.

### GENERAL REPORT OF THE COUNCIL, STUDENT LOAN FUND, AND SCIENTIFIC FOUNDATION

The reference committee recommended adoption of the second and third proposed standing rules published in the general report of the Council and offered an alternative to the first rule relating to the registration of voting delegates. The committee stated that it had been adequately demonstrated in the past that the issuance of credential cards had not served a sufficient purpose to continue this procedure and recommended adoption of a rule to the following effect:

> Delegates and alternates will sign registration slips at the time they are admitted to each session of the House. Their names will be checked against a list of authorized delegates and alternates previously submitted by the county societies to the state headquarters. If an uncertified delegate wishes to be admitted, he will be referred to the Credentials Committee for its recommendation as to whether he should be admitted.

The committee also thanked the Wisconsin Surgical Society for its generous contribution to the Student Loan Fund and expressed appreciation to the woman's auxiliaries for their several contributions. The committee urged continued support of members to this most worthy cause and reminded the House that contributions to the Fund are deductible for income tax purposes.

The reference committee strongly recommended adoption of all recommendations applicable to the establishment of a Scientific, Educational, and Charitable Foundation as they appeared in the Council's report.

On motion of Doctor Morton, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, this section of the report was accepted.

## REPORT OF THE TREASURER

On motion of Doctor Morton, seconded by Dr. R. L. MacCornack, Sr., Whitehall, carried, Dr. F. L. Weston, Madison, was commended by the House of Delegates for his untiring efforts as treasurer of the Society.

## REPORTS OF THE SECRETARY AND AMA DELEGATES

The reference committee commended the secretary and his staff for their ability in assembling all the reports and recommendations of the Council and the many committees of the Society, numbering over 200 physicians among their members. It noted also that many hours were spent in arranging committee meetings, getting out agendas in advance, and reporting to the Society.

The committee, in considering the report of the AMA delegates, thought it would be highly desirable if information regarding matters to be considered by the American Medical Association were circulated to the Wisconsin membership before the sessions of the AMA so that members might have an opportunity to discuss these problems within county societies and express their views to the delegates.

The reference committee, therefore, recommended to the House that it request the AMA delegates to support a resolution that action on any resolutions not submitted to the AMA 30 days in advance of a session be held over to the next session, except, of course, where an appropriate committee rules that a resolution requires immediate action.

On motion of Doctor Morton, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, this section of the report was accepted.

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On motion of Doctor Morton, seconded by Dr. R. H. Bitter, Oshkosh, carried, the report, as a whole, was adopted.

# REPORT OF REFERENCE COMMITTEE ON STANDING COMMITTEES

Dr. G. W. Carlson, Appleton, chairman, presented the report of this committee, which was composed of Drs. E. C. Cary, Reedsville; C. W. Stoops, Jr., Madison; C. A. H. Fortier, Milwaukee; and K. L. Bauman, Lancaster.

Doctor Carlson noted that in preparing the report the committee had not included a statement as to each recommendation included in committee reports considered but rather pointed up what were deemed the most important points in each so that delegates would particularly note specific matters on which they were acting. Blanket approval of the other recommendations was suggested by the reference committee.

On motion of Doctor Carlson, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, this section of the report was accepted.

## COMMITTEE ON BLOOD BANKS

The reference committee recommended adoption of the report of the Committee on Blood Banks. It further noted that in the supplementary report of the Maternal Mortality Committee the suggestion was made that all hospitals develop effective blood programs to assure that adequate blood supplies are available in emergencies. The reference committee recommended that the Blood Bank Committee be charged with the responsibility of developing these programs, working in close cooperation with the Division on Maternal and Child Welfare.

On motion of Doctor Carlson, seconded by Dr. A. A. Quisling, Madison, carried, this section of the report was accepted.

## COMMITTEE ON CIVIL DEFENSE

Doctor Carlson called upon Dr. Marc Musser, chairman of the Committee on Civil Defense, to elaborate orally on recommendations made in his committee's printed report. Doctor Musser stated that the vast problem of civil defense organization is essentially a public responsibility, and the agencies charged with that responsibility should have adequate personnel and financing to do the job required for the safety of the people of Wisconsin. Therefore, the committee had made the six recommendations contained in its printed report.

On motion of Doctor Carlson, seconded by Dr. L. E. Fazen, Jr., Racine, carried, this section of the report was accepted.

## COMMITTEE ON MILITARY MEDICAL SERVICE

The committee noted that a great amount of time had been given to this activity not only by Dr. Frank Weston as chairman of the Wisconsin Advisory Committee to Selective Service, but by the councilors of the Society and other physicians contacted for information as to the availability or essentiality of a particular physician. These physicians are largely responsible for the smooth operation of the Selective Service system in this state, and their advice has proved invaluable to the Advisory Committee in making its recommendations to the State Selective Service system.

Those in the Selective Service office were also commended for the splendid way in which they have worked with the Advisory Committee. The office of Colonel Ben Courtenay and Major Curt Shepard has courteously and respectfully accepted the recommendations of the Advisory Committee and in all ways has evidenced its willingness to do an effective job in this activity.

The following report was printed in the *Handbook for Delegates:*

On motion of Doctor Carlson, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, this section of the report was accepted.

## THE VETERANS MEDICAL SERVICE AGENCY

The reference committee urged that all members of the Society utilize the facilities of the Agency in the home-town care of veterans. Physicians and veterans alike should be advised of the availability of the Agency's service so that local treatment can be administered these patients whenever possible. Delegates were urged to carry this message back to their county societies.

On motion of Doctor Carlson, seconded by Dr. L. W. Schrank, Beaver Dam, carried, this section of the report was accepted.

## COMMITTEE ON CANCER

R. P. Welbourne, chairman; A. R. Curreri; A. C. Taylor; P. B. Blanchard; W. E. Bargholtz; K. G. Pinegar; R. B. Larsen; W. S. Bump; J. E. Conley; G. I. Uhrich; J. W. Conklin; Lucille Radke; and R. J. Schacht.

Major attention of the Committee on Cancer this past year has been directed to the professional education of physicians and dentists and toward effecting a closer working relationship between the State Board of Health and the two divisions of the American Cancer Society on programs of mutual interest and concern.

As the Committee on Cancer of the State Medical Society, the physicians represented are concerned that all agencies interested in the field of cancer control exchange information and plan programs together. In a report of the American Cancer Society following a review of the cancer control programs in Wisconsin it was recommended strongly that the Committee on Cancer of the State Society not content itself with serving as the medical and scientific committee of the Wisconsin Division alone, but that it take an active role in correlating programs throughout the state. As a result of this recommendation, a Coordinating Committee on Cancer was established with representation from the two divisions of the American Cancer Society, the State Board of Health, and the State Medical Society. Meetings of this group to date indicate need for continued joint planning, and it is anticipated that during the ensuing year similar meetings will be held to exchange ideas and to plan programs in a coordinated fashion.

### Lung Cancer Survey

Major attention of the Coordinating Committee on Cancer has been directed to an evaluation of the lung cancer survey and to suggestions of the American Cancer Society that states consider a mass examination in this field. The Coordinating Committee called a meeting to which representatives of the state radiologic group and Wisconsin Anti-Tuberculosis Association were invited. After considerable discussion it was agreed that no separate program would be carried out in this one field alone, but that all mobile units would emphasize the need to have older groups screened, and that lay organizations, such as the Cancer Society, the Heart Association, and others would assist with the development of publicity to encourage wider participation of older persons in the mobile unit program. It was also recommended that the State Board of Health and the W. A. T. A. re-evaluate the use of microfilming in hospitals, and where such equipment is not being used to the maximum efficiency, it be transferred to hospitals where greater use could be assured. It was further suggested that the findings of these hospital services be studied to see what relationship there is to lung cancer and the older age group.

The Coordinating Committee has also set up a program for the distribution of the publication, CA, and the special bulletin provided physicians through the State Board of Health, so that an evaluation of these two publications can be made by the physicians of the state and a determination made as to which is preferred. In this way it is hoped that overdistribution of cancer material will be avoided, still providing physicians with free copies of the publications they prefer to receive.

### Physician–Dentist Programs

The second major interest of the Committee on Cancer this past year has been the development and stimulation of a series of special teaching programs for physicians and dentists, with emphasis on oral cancer. Five such meetings were held in 1954: at Eau Claire, Wausau, Appleton, Janesville, and Green Bay. In addition to the subject of oral cancer, talks were given on cancer of the uterus, the lower bowel, the lung, and the breast, and on cytologic examinations (including biopsy technics). Outstanding speakers from Wisconsin and nearby states were faculty members.

The response of both physicians and dentists to these programs was significant. The program was planned so that the oral cancer portion was presented in the late afternoon and in the evening, with the thought that dentists might not be interested in the other topics presented. But the dental attendance was strong throughout the meetings which indicated a great interest in scientific fields outside of the particular area of the oral cavity.

Attendance was about equally divided between dentists and physicians with the following as the registered attendance at each of the meetings: Eau Claire, 44; Wausau, 63; Appleton, 66; Janesville, 91; Green Bay, 97, or a total of 361 for the five meetings.

The success of these meetings, both by way of participation and interest shown, has encouraged the Committee on Cancer to ask the Wisconsin Division of the American Cancer Society to develop similar programs in other areas. Plans are under way to do this, and it is also hoped that the Milwaukee Division will develop similar programs within its area.

### Lay Education

In keeping with its general philosophy the Committee on Cancer has continued to develop lay education programs around the theme, "Every doctor's office is a detection center." This places a direct

responsibility upon the practicing physician to give cancer primary attention in all older patients and to encourage well-patient examinations by setting up a procedure so that the obvious sites where most can be done (the skin, the oral cavity, the breasts, the cervix, the prostate, the anus, and the lower bowel) can be examined without undue loss of time and without too great an expense to the patient. By proper interpretation to the patient any cancer phobia can be avoided. Yet, a consciousness of the early signs of cancer can be developed within the patient, so that when they occur, he will seek competent medical advice immediately.

While great progress has been made in the early detection of cancer through full cooperation on the part of most doctors, it is disturbing to receive occasional reports that "the doctor doesn't want to examine me unless I have specific symptoms." It is hoped that by routine examination of their regular patients, all physicians will meet the challenge of early detection of cancer and will be sympathetic with the new patient who seeks advice and counsel on this subject.

### Recommendations

1. Every doctor should set up a routine for screening examinations of well patients and encourage older patients to have periodic checkups.

2. Every pregnant patient should have special attention directed to her breasts and reproductive organs so that any early cancer can be detected before it becomes so advanced that medical help is of no avail.

3. Full support should be given the interprofessional programs between physicians and dentists by way of direct participation and by encouraging dentist acquaintances to attend.

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The reference committee emphasized the need for greater efforts to educate the lay public as to the importance of periodic checkups. It commended the Committee on Cancer for the development during the past year of postgraduate teaching programs which were attended by members of the medical and dental professions alike. It further recommended that a message of appreciation should be conveyed to the Wisconsin State Dental Society for its interest and participation in the clinics and that the Executive Committee of the Wisconsin Division of the American Cancer Society be commended for its part in developing these programs.

On motion of Doctor Carlson, seconded by Dr. M. D. Davis, Milton, carried, this section of the report was accepted.

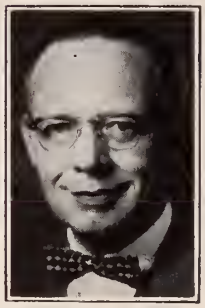
The reference committee offered the following resolution for consideration by the House:

WHEREAS, Great interest has been evidenced by physicians and dentists alike in special teaching programs on cancer; and

WHEREAS, The Committee on Cancer has urged that full support should be given these interprofessional meetings by way of direct participation by both groups;

THEREFORE, BE IT RESOLVED, That each county society be asked to arrange a meeting of physicians and dentists in a manner similar to the special teaching programs conducted during the past year.

On motion of Doctor Carlson, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, the resolution was approved.



## COUNCIL ON MEDICAL SERVICE

D. E. Dorchester, chairman; T. D. Elbe; J. F. Maser; D. N. Goldstein; R. L. MacCornack; C. G. Reznichek; D. M. Willison; J. S Devitt; and W. J. Fencil.

The following report was published in the *Handbook for Delegates:*

To the medical profession the terms "good medical service" and "good public relations" are synonymous. The degree to which the profession is able to provide high quality medical service to the patient's satisfaction is the measure of its public relations. Good medical service and good public relations result from complex scientific, economic, and social factors carefully blended by the physician to produce a pleasant psychologic reaction. No single factor particularly outweighs another; yet, not until the separate elements of public relations and medical service are isolated can they be studied with an eye to improvement of the whole.

In that light the Council on Medical Service asks the attention of the physicians of Wisconsin to a most significant public relations problem—the availability of medical care to the public at all times, day or night. Bitter reports of unsuccessful attempts to reach a physician in an emergency do not win friends for the profession. Only the assurance that medical care is available around the clock will develop appreciation and satisfaction on the part of patients. Because the problem demands action that is swift and sure, the Council makes the following report and recommendations:

### Emergency Medical Services

While a physician is as free to choose whom he will serve as is the citizen free to choose the physician to serve him, it is clear that a physician "should . . . respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service."

That is the Principle of Medical Ethics to which the physician subscribes, and it is his obligation to himself and his fellow men to practice his precepts.

Emergencies requiring medical care are more, however, than an obligation of the profession itself. The public guards itself against the hazard of fire and similar catastrophe; but without the physician it cannot similarly guard itself in the medical emergency. The people cannot, and should not, think of

the physician as they think of a utility—something in the character of an electric current that is almost always available at the flick of a switch. Physicians are people, not the product of some law of physics. They possess all the frailties common to mankind, including the need for sleep, relaxation, and rest. Their services in times of emergency are not like those of the utility, available without a certain degree of participation on the part of the public.

It should be plain, then, that the problem is one of cooperation between the public of a community and the physicians of that community.

To define the problem requires a definition of "emergency" in terms of medical needs. An emergency should be unpredictable, even in light of experience. It should be something which no one can reasonably foresee, even as a possibility within some given area or over a period of time.

The traffic hazards of certain highways become well known to law enforcement officers. These officers can and do predict the occurrence of accidents on those highways. Even though unable to predict exactly where, or at what time, they are prepared for emergency medical service. In Dane County, for example, there is an excellent county police system with squad cars equipped as ambulances.

Civic leaders are well aware that large public gatherings are almost certain to produce a number of medical emergencies. They establish first-aid stations and stand-by ambulance service and thoughtfully notify local physicians or hospitals of the possibility of emergency.

Many industries and even communities wisely prepare for unexpected events in business or farming by maintaining rescue squads with such simple and inexpensive equipment as stretchers, Pulmotor and oxygen equipment, and a well-stocked first-aid kit.

Institutions, such as jails, mental hospitals, and similar places, generally have specific physicians on call. They have planned procedures, well known to all employees, in event those physicians are not available.

A family, cognizant of its responsibility in the entire area of medical care, generally has developed its own relationship with a physician and knows what steps to take should that physician be unavailable. More than that, by being familiar with the danger symptoms of illness, the family does not postpone itself into an emergency.

Is there, then, a problem of medical care in emergencies? Most certainly there is. The problem may be created by physicians themselves who have failed to do enough joint planning so that the services of at least a portion of the medical population are always available.

The problem can be accentuated by a press which finds that "half a story" makes more interesting reading than "all the facts." It may enjoy criticizing events more than providing constructive advice.

Many people are themselves to blame for what they term the "refusal" of a physician to accept a call. Many times there is no emergency at all. They become frightened and hysterical and then unreasoning.

But then there are those very legitimate cases when the emergency exists, and repeated calls and repeated refusals constitute a truly frustrating experience—simply because people, and physicians are among them, have not planned.

The State Medical Society of Wisconsin has surveyed every county in Wisconsin. It is satisfied that, to the extent to which the problem can be solved by physicians, there is a reasonable device for answering emergency calls in virtually every area of the state. But physicians cannot supply the whole answer themselves.

It seems to the Society that community leadership must join with the physicians in the preparation of adequate devices to assure maximum protection. To this end, the Society makes the following recommendations:

1. In every community where there is a public hospital, it is suggested that the emergency medical service plan be administered through the hospital. If it does not actually have a physician on duty, the hospital knows where to reach a medical doctor immediately. For a patient with a real or serious medical or surgical emergency, the hospital's facilities and equipment offer excellent protection. Large cities might wish to follow the example of Milwaukee, Madison, and Green Bay, which have established more formal telephone emergency service bureaus.

2. In communities where there are no hospitals, emergency medical calls should be handled through the local police or telephone office.

3. In either event a committee of physicians and laymen should meet periodically to review the procedures and the adequacy of the emergency service plan.

4. The pattern of handling emergency calls in any community should be made known by the physicians of the area to all law enforcement officers, firemen, and others by open public meeting once each year. It should be the responsibility of any public official or other person entrusted with the care of unrelated individuals to assure himself that he has planned proper procedures for emergency situations.

5. County medical societies and communities seeking to improve emergency medical services are urged to contact the State Medical Society for advice and information.

### Public Relations and Public Information

A wide variety of public relations and public information projects has occupied the Council on Medical Service during the past year. These activities are reported as a matter of information so that the membership may appreciate their influence in behalf of the public and the profession.

*Physicians' Placement Service.* This department of the State Medical Society has more than tripled its activity during the past year. As a result of improved information services, the physician seeking a location in Wisconsin has available to him the most comprehensive data on scores of opportunities in practice, including positions open to locum tenens and in the full range of specialties. Wisconsin com-

munities seeking physicians obtain advice on attracting and keeping a physician as well as names of M.D.'s interested in practice.

Of 90 physicians who contacted the service since January, 15 were directly placed by the service in Wisconsin communities, 20 located in Wisconsin communities not listed by the service, and 55 located in other states. Currently, the Placement Service lists nearly 60 communities which seek physicians and about 170 physicians who are seeking practices.

The Physicians' Placement Service can fulfill its function most effectively as soon as every physician, whether he is seeking a practice or an assistant, recognizes it as an arm of the State Medical Society dedicated to personal service for him. Communities needing physicians should look to this service first as a center of information and advice.

*National Rural Health Conference.* Wisconsin physicians and rural people will have an opportunity that is not likely to repeat itself soon when the American Medical Association's National Conference on Rural Health is held in Milwaukee on February 24–26, 1955. The Council's efforts in bringing the conference to Wisconsin will be crowned with success only if doctors and laymen give their full support to the meeting with attendance and active participation.

*"The March of Medicine."* The public service radio program of the State Medical Society continues to expand in scope and popularity. A year ago this 15-minute program was broadcast weekly by 39 radio stations. Now 42 stations carry the program. "Fan mail" continues to increase with some programs producing as high as 500 letters.

Fans of "The March of Medicine" will soon be able to "see" as well as "hear" the health program directed by Dr. Robert C. Parkin. Starting in September the program will be televised via WHA–TV to an audience within a 20-mile radius of Madison. As soon as possible, kinescoped versions of the same program will be available to other television stations on a public service basis.

*Health Education and Information.* Among the numerous other activities of the Council on Medical Service are the following: A tape recording loan service of "The March of Medicine" health talks through which more than 350 tapes were circulated to nearly 80 high schools during the past school term; studies leading to improved automobile safety and first-aid training; cooperation with the Wisconsin Press Association in developing a trial physical examination program among residents of a single county; loan packets and speakers on a wide variety of health subjects; support of the Wisconsin Public Health Council; distribution of a brochure for recruitment of allied medical personnel; and continued guidance to the state 4–H Club health program.

### Nursing Education

Exploratory meetings have been held by the Committee on Nursing Education of the Council on Medical Service. Members of this committee are: Drs. J. S. Devitt, chairman; G. S. Custer; A. H. Heidner; G. B. Merline; R. C. Parkin; J. D. Schroeder; W. J. Tucker; J. H. Wishart; and Mrs. Victor Falk.

The committee finds that it can make no more than a progress report. Preliminary discussions and investigations bring the committee to the belief that the most direct and immediate relief for the current nursing personnel shortage can be achieved by greater emphasis on recruitment and education of trained practical nurses. During the coming year the committee hopes to delineate this problem further and explore various means for providing a solution.

### Industrial Health

During this past year more than 50,000 Wisconsin employers covered by Workmen's Compensation have received printed panels listing all members of the State Medical Society who have signified their desire to participate in the Open Panel Program. More than three-fourths of the entire membership participates in this program. This is a valuable service to members by identifying them with industrial health programs in the workers' respective communities. It has been welcomed also by employers as a means of meeting the requirements of the Wisconsin Statutes in relation to compensation care.

As a corollary of this activity, the Conference Committee on Open Panels continues to hold itself ready to handle disputes between physicians and employers or insurance carriers. The fact that the few cases brought before the committee could be handled by mail reflects increasing acceptance of the program, both by the physicians and the other participants.

During this past year, one "in-plant" clinic was held in Milwaukee. This meeting was held in cooperation with the Medical Society of Milwaukee County and provided a means of bringing important matters of industrial health to the attention of more than 200 physicians, industrial nurses, and representatives of management in the area.

In 1948 the Society's Committee on Industrial Health published an important *Guide for Medical and Nursing Personnel* in cooperation with the Industrial Hygiene Unit of the State Board of Health. This has had wide distribution throughout industry, not only in Wisconsin, but in many other states. The passage of time indicates the need for a revision of this Guide, and it is hoped that it can be accomplished during the ensuing year.

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The reference committee noted that an unusual opportunity will be offered in February, when the AMA's National Conference on Rural Health will be held in Milwaukee. It urged that physicians give their full support to this meeting by attendance and active participation along with the public.

The reference committee also commended the Woman's Auxiliary of the State Society for its efforts to further the education of nurses as well as develop the interest of prospective nurses through scholarship funds, literature, and the like.

On motion of Doctor Carlson, seconded by Dr. E. C. Cary, Reedsville, carried, this section of the report was accepted.

## COMMITTEE ON PUBLIC POLICY

J. M. Sullivan, chairman; J. R. Schroder; J. A. Enright; S. E. Gavin; J. K. Curtis; president, president-elect, and secretary, ex officio.

The following report was published in the *Handbook for Delegates:*

The Committee on Public Policy is established by the Constitution and By-Laws of the Society and has, as its chief function, the consideration and presentation of public health recommendations to legislators and other public officers. It is the legislative committee of the Society, in addition to its other functions.

Of course, 1954 has been a non-legislative year. The committee will become much more active the balance of this year and during the active legislative period which commences in January of 1955 and continues until adjournment, usually in June.

### The Medical Practice Act

The committee has met this year, however, to receive and consider recommendations of its staff and its several *ad hoc* subcommittees. It has initiated further studies and has met with the members of the Board of Medical Examiners to discuss the Board's experience in its first year of administration of the revised Medical Practice Act. As members will recall, that Act was very extensively amended and modernized under the sponsorship of the State Medical Society during the last session of the legislature.

Specifically, the Board of Medical Examiners has recommended to this committee several minor amendments to the Medical Practice Act. These recommendations include the request that the committee consider the advisability of revising those provisions which relate to reciprocity with the armed services. This and other recommendations are under consideration.

### Study of Cult Practices

An important and exhaustive study embracing cult practices in Wisconsin is well under way. Already there are strong indications that practitioners in several of the cults are exceeding the limits of their respective licenses. There is evidence that several of the proprietary schools in which cultists are trained have abandoned cult teachings and are, in effect, the old medical diploma mills of the last century. Lip service is paid the standard medical subjects and texts; the names of Pasteur and Lister are heard in the halls, and the graduate openly invited to engage in medical practice for which he is neither trained nor educated.

### Shortage of Medical Personnel

The committee has met with several state officials and has consulted with several state departments in an effort to alleviate a critical shortage of medical personnel in state service. Although this has been a problem which has received the continuing interest and attention of the Society, no complete and permanent solution has been reached.

Several legislative proposals seeking to attract physicians into state service have been made by members of the profession and others. These proposals are in process of evaluation and consideration.

### Definition of Chiropody

During the 1953 legislative session, representatives of the chiropodists requested the support of medicine in a proposed amendment to the statutory definition of chiropody. The definition of chiropody permits certain minor surgical procedures upon the foot, but prohibits such surgery if it "involves" the bones, ligaments, muscles, nerves, or tendons of the feet. In the opinion of the chiropodists this was in need of clarification.

The Committee on Public Policy felt that there was an inadequate period of time to arrive at any conclusion permitting the introduction of legislation in 1953. The chiropodists agreed to withhold their proposal to permit an adequate study in the interim prior to the 1955 session.

Accordingly, this committee appointed an *ad hoc* committee of orthopedic physicians to consider the subject in detail. Its deliberations resulted in the recommendation that minor surgical procedures be limited to those upon the foot which were not "directed primarily" toward the treatment of, or correction of, afflictions of the bones, ligaments, muscles, nerves, or tendons of the feet.

That recommendation was acceptable to the chiropodists and was approved by this committee and by the Council of the Society at its July meeting.

### Reporting Requirements

All statutes and regulations which require a physician to report various diseases, gunshot wounds, deaths under mysterious circumstances, and the like are under examination and study by this committee. It is its position that any reporting requirements which perform no real public safety or public welfare function should be eliminated as an annoyance to members of the profession. Others should, perhaps, be strengthened. Consideration is being given to the advisability of requiring that narcotic addicts be reported to appropriate authorities.

### Other Revisions

The Committee on Public Policy has maintained a close liaison with various interim legislative committees which are considering a sweeping revision of the criminal code and of those sections of the Wisconsin Statutes relating to the enactment and enforcement of administrative rules. In both of these fields the medical profession has a direct interest.

There is good reason to believe that the next session of the Wisconsin Legislature will witness the introduction of licensing legislation by cult groups. Several of the studies now under way in this committee are designed to supply factual information with which to combat such legislation which is inimical to the public health.

### The Physician's Part

This committee recognizes the seriousness of its responsibilities and appreciates that its success is

dependent upon the cooperation and understanding of each member of the profession. During the next legislative session, which commences in January 1955, it will keep the general membership informed as to the status of all medical and public health legislation before the legislature. It will explain its position on that legislation to the physician membership and to the members of the legislature. In the last analysis, however, the outcome of that legislation depends, above everything else, upon the factual information given each legislator by his physician at home. Medicine provides primarily the listening post and research facilities for legislators.

On motion of Doctor Carlson, seconded by Dr. P. B. Blanchard, Cedarburg, carried, this section of the report was accepted.

## COUNCIL ON SCIENTIFIC WORK

J. W Gale, chairman; P. A. Midelfart; S. A. Morton; M. G. Rice; L. G. Kindschi; R. S. Baldwin; J. S. Hirschboeck, ex officio; and W. S. Middleton, ex officio.

The following report was published in the *Handbook for Delegates:*

### Preface

It is with more than customary pride that the Council on Scientific Work outlines on the following pages the extent of and favorable reactions to the many teaching programs and related conferences conducted during the current year. A review of the programs outlined will emphasize the many points where the membership has received direct services for its financial support of Society activities.

The diversity of activities in relation to postgraduate education and associated conferences reflects the expanding activities of the State Medical Society of Wisconsin. A decade ago its scientific programs were restricted largely to the yearly Annual Meeting and one series of circuit teaching clinics. With the advent of war and increased interest in health of workers an active industrial health program was added as a part of the Society's activities. During the years the scope of this program has shifted to reflect the current problems in industrial medicine. This past year the major emphasis of the industrial health program has been properly directed to hearing loss, the medical profession's recommendations to industry concerning proper steps to take to prevent such loss, and the proper evaluation of loss which cannot be avoided with the best of protective devices.

Under the stimulus of the American Medical Association increased attention has been directed to school health problems, and the interest of dentists in problems of cancer has prompted the development of special conferences which have brought members of the two important professions of medicine and dentistry together on a scientific level. Both of these activities are reported in detail through other committees.

All the programs described in this report have provided direct services to members of the Society, and many of them have had the added advantage of placing the Society in a position of positive leadership in meeting special medical problems in the activities of other groups.

In terms of service to members the 1954–55 programs have presented a diversity and geographic spread so that every member of the Society has had an opportunity to participate. In terms of public relations the School Health Conferences, Industrial Health Clinic, and the Cancer Clinics provided avenues for physician leadership and cooperation which should redound to the credit and strength of the Society.

In total it has been a program which is worthy of the reputation of leadership established by the Society in its many fields of endeavor. It is hoped that those most closely associated with the affairs of the Society, namely the House of Delegates and Council, agree that the activities reported in this brief resume have been worth the time, money, and effort expended to present them to the membership and the many other lay and professional groups included in the clinics or conferences.

### 1. Circuit Teaching Courses

*Over-all Evaluation.* The circuit teaching courses this past year have presented a variety of teaching material to the membership of the State Medical Society. Attendance was not as large in total as that of the clinics of 1953–54, partly because in 1953–54 one more circuit was included in the program and because this past year some sparsely populated areas were served. Participation was good in terms of percentages based upon physician population, but small in terms of actual members attending.

**ATTENDANCE 1953**

| | | | | | | Total |
|---|---|---|---|---|---|---|
| January | Lake Delton | 43 | Sparta | 24 | Eau Claire | 51 | 118 |
| February | Lancaster | 28 | Janesville | 54 | Fond du Lac | 46 | 128 |
| March | Beaver Dam | 33 | Marshfield | 34 | Neenah | 78 | 145 |
| April | West Bend | 40 | Shawano | 28 | Stevens Pt. | 50 | 118 |
| May | Delavan | 51 | Sheboygan | 59 | Green Bay | 42 | 152 |
| June | Siren | 39 | Minocqua | 52 | | | 91 |
| Total | | | | | | | 752 |

Average per circuit: 125 Average per clinic: 44

**ATTENDANCE 1954**

| | | | | | | Total |
|---|---|---|---|---|---|---|
| March | Monroe | 41 | Kenosha | 44 | Portage | 61 | 146 |
| April | Eau Claire | 26 | Stevens Pt. | 45 | Appleton | 50 | 121 |
| April | Platteville | 40 | Oconomowoc | 40 | Manitowoc | 50 | 130 |
| May | Chip. Falls | 30 | Pinecrest | 22 | Rhinelander | 42 | 94 |
| June | Racine | 36 | Elkhart Lake | 65 | Menominee, Mich. | 24* | 125 |
| Total | | | | | | | 616 |

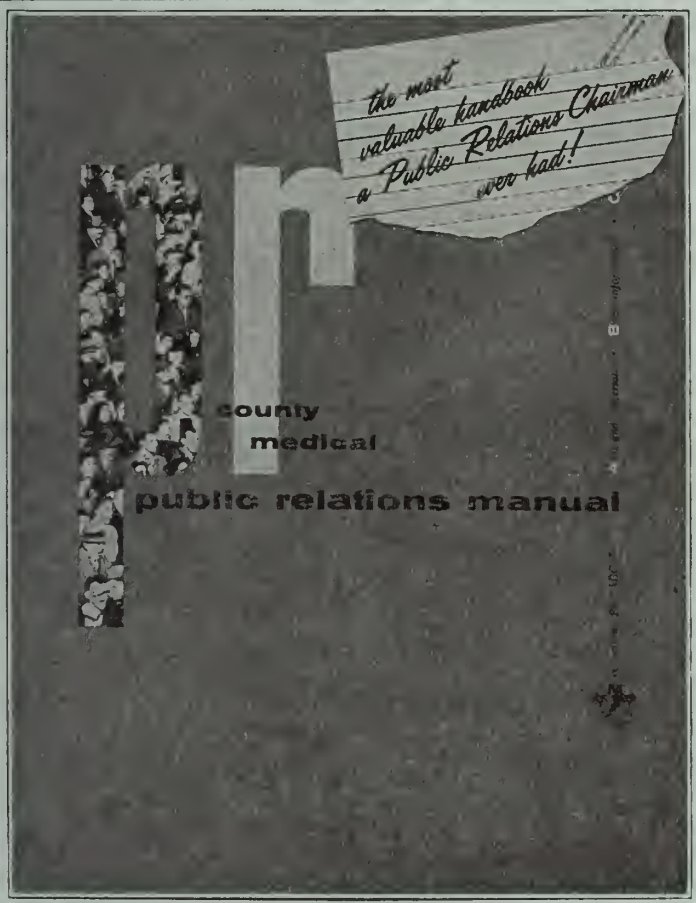
*(Actual attendance 85, but balance Michigan M.D.'s)

Average per circuit: 123 Average per clinic: 41

*(Continued on page 691)*

# THE MEDICAL FORUM

## PUBLISH PR MANUAL FOR COUNTY SOCIETIES




PR Manual cover is heavy cardboard.

Madison, Nov. 30.—The "why" and the "how" of a public relations program for the county medical society has been gathered for the first time into a comprehensive PR textbook, just published by the Public Relations Department of the American Medical Association. The result of years of research in successful PR programs throughout the country, the *County Medical Public Relations Manual* provides a step-by-step outline for PR action already proved in the field.

**The manual offers a practical approach to the problems of promoting and maintaining good professional and community relations. Geared to fit the needs and facilities of the average county society, the material is readily adaptable to the internal and community PR programs of either large or small groups. In addition to containing general public relations information, the book explains how to organize for effective action and outlines a working format for specific PR programs.**

Studies by the AMA have revealed eight programs to be basic for solid county public relations and these eight are taken up in detail in the manual. Considered from the standpoint of both organization and promotion are: Emergency Call Systems; Mediation Committees; Press Relations; Speakers Bureaus; Society Member Indoctrination; Provision of Medical Care for All; Public Service Activities; and Citizenship Activities.

Societies which have already put some or all of these basic programs into operation will find the list of supplementary projects for each program a valuable addition to the manual. The book also contains a list of public relations aids and an index of references.

**The *County Medical Public Relations Manual* is being distributed through the state medical societies and is available now, free of charge. Every Wisconsin county society should have at least one copy. Obtain your society copy by writing to The State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.**

## JUDGE ORDERS "TUNNEL" CLOSED

Madison, Nov. 22.—The Lone Rock "uranium tunnel" must be closed because its operator, Kenneth Crook, is using it to practice medicine without a license, ruled Circuit Judge A. W. Kopp, Platteville, on November 22. The ruling, ending the court action begun last August when the state filed charges against Crook, is expected to affect about a dozen other "tunnels" which sprang up following the trial's wide publicity.

**A 36-year-old farmer, Crook opened his "tunnel" last May. He defended himself in court by claiming that he made no attempt to diagnose or treat the hundreds of people who paid $1 an hour to sit in the 16-foot room lined with bags filled with low-grade uranium ore. Judge Kopp stated, however, that Crook "at all times knew and continues to know the use to which said tunnel is being put. He intended that the tunnel be so used for treating the sick."**

In the windows of his establishment, Crook displayed testimonials and also required patrons to sign printed forms releasing him from all claims for injuries or damages.

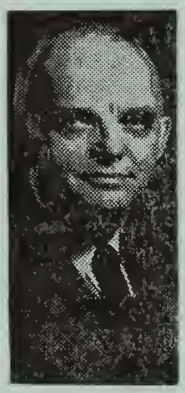
**The other "tunnels" are now under investigation by the state, according to Deputy Attorney General Stewart G. Honeck who prepared the state's case.**

Judge Kopp directed the attorney general to draft a permanent injunction against Crook.

# State Conferences Furnish Data For Nursing Education Survey

Madison, Nov. 15.—Nurses, physicians, and educators met with a special research team at three conferences in Wisconsin during November to discuss the status of nursing education in the state. The conferences, held at Madison November 8, Rice Lake November 10, and Milwaukee November 12, were sponsored by the Commission to Develop a State-Wide Plan for Nursing Education, a committee of the Wisconsin State Department of Nursing.

**The Commission was created to obtain recommendations for improved nursing education and to explore problems which are particularly severe in Wisconsin. Dr. A. H. Heidner, West Bend, a member of the Committee on Nursing Education of the State Society's Council on Medical Service, and Dr. B. A. Waisbren, Milwaukee, are members of the Commission.**



Dr. Curran

The conferences were held to assist the six-member study team from the Institute of Research and Service in Nursing Education of Teachers College, Columbia University, in making direct inquiries for its survey. This information, combined with data from questionnaires filled in by physicians and with detailed investigations of recruitment, training, and licensing procedures in the state, will be the basis for the team's recommendations.

Directing the research team is Dr. Helen L. Bunge, executive director of the Columbia Institute. Members of the team and the fields they represent are: Dr. Jean A. Curran, medicine; Miss Eleanor C. Lambertsen, nursing service administration; Miss Mary Liston, psychiatric nursing; Miss Louise C. Smith, public health nursing; and Mrs. Eugenia K. Spalding, advanced nursing education.

The main points emphasized during the conferences were these:

1. There is great need for a state-wide program of postgraduate education for nurses. In addition, Wisconsin educators believe that nursing education has a greater place in institutions of higher learning.

2. The various classifications and levels of education of nurses are not clear for purposes of administration, recruitment, and patient care.

3. Physicians' demands of nurses have undergone considerable change in the past few years, possibly requiring changes in nursing education and delegation of responsibility.

4. Since nurses tend to stay near the place where they are trained, it is desirable to develop schools which will serve the less metropolitan areas of Wisconsin. Northern Wisconsin, particularly, needs trained practical nurse schools but faces the problem of financing.

5. Studies should be made of the possibility of expanding trained practical nurse education programs in regular academic institutions as well as vocational schools and nursing education should be organized so that a student may begin a practical nursing course and proceed to the R. N. program without loss of credit. Several requests were made, also, for study of Wisconsin registration procedures particularly in regard to reciprocity.

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TENTH NATIONAL CONFERENCE
ON RURAL HEALTH
February 24–25–26, 1955
Schroeder Hotel
Milwaukee, Wisconsin

Sessions Begin: 2 p.m. February 24
Sessions End: 3 p.m. February 26
Panel discussions on Farm and Home Safety—Family Responsibility for Health—Using Present Health and Medical Care Resources—Successful Rural Health Projects.

Banquet—February 25
"Rural Health and World Peace"
Walter H. Judd, M.D., Congressman from Minnesota

Sponsored by
The Council on Rural Health,
American Medical Association
and
The State Medical Society of Wisconsin

# Racine Society Holds Medical–Press Meet

Racine, Nov. 17 — About 60 representatives from the Racine County Medical Society, press, radio, hospitals, and police met for a medical–press conference to smooth the way for a closer working relationship between the groups. The group met at the Racine Country Club, November 17.

**Dr. G. L. Rothenmaier, Racine, president of the medical society, directed the discussions. Dr. Beatrice O. Jones, chairman of the Public Relations Committee of the society, served as moderator for a 2-hour open forum session.**

"We have no trouble with reports on accident cases," stated J. Donald McMurray, editor of the Racine *Journal–Times*, "but we do want more information on medical and health news."

McMurray said his paper is "always willing to check a story with doctors who provide information." But he explained that there will always be instances when it is extremely difficult to reach a physician, and a story must get in to get a headline.

### SHOULD DEVELOP GUIDE

**McMurray made a plea for the development of a guide for distribution to all parties concerned with health and medical news so that each knows his responsibility and the authority he might have for release of news.**

Dr. C. G. Reznichek of Madison, member of the Council on Medical Services of the State Medical Society, discussed police cases, illness, photography, and press codes.

Karl H. York, administrator of St. Luke's Hospital, Racine, explained local policy for the release of information about patients. The legal aspects of releasing medical news to the press were expressed by Alfred LaFrance, Racine, president-elect of the Wisconsin State Bar Association.

**LaFrance pointed out that, since 1839, Wisconsin physicians have been prohibited by law from releasing any information about patients without the patient's consent. There are three exceptions for certain types of legal proceedings.**

At the conclusion of the meeting, Dr. Jones announced that the Racine County society plans to develop a guide for local use and is developing a more active public relations committee.

# 10 PER CENT OF FEDERAL BUDGET TO GO FOR HEALTH

## Total U. S. Health Bill Around $12,000,000,000

Washington, D. C., Dec. 6.—The Federal Government this fiscal year (July, 1954—June, 1955) is spending an estimated $2,141,681,-661 for its health, medical, and related activities which range from construction of multimillion dollar hospitals to maintenance of clinics.

**According to a report from the Washington Office of the American Medical Association, Federal Government expenditures for health increased about 8 per cent over last year. The AMA points out that this amount is equivalent to 10 per cent of the $22,000,000,000 that represents the entire U. S. budget not including defense security costs.**

The Department of Commerce estimates the total U. S. health bill at $12,000,000,000. Thus, the Federal Government's expenditures for health activities is approximately 1/6 of all money spent in any way for medical and health items in this country annually, including the costs of drugs, dental care, pharmaceutical items, and drug store sundries.

Department of Defense expenses for health and medical care went up more than $300,000,000 over last year's expenditures. It is scheduled to spend $845,500,000 during the current fiscal year.

The Veterans Administration expects to spend $748,738,563 on its health and medical care program during the fiscal year. This is an increase of about $1,000,000 over last year. Most of this goes for in-patient care in VA hospitals. Such care is provided in the 172 VA hospitals which handle an average of 105,000 patients daily. The VA reports that 53.8 per cent of the veterans under treatment for disease or injury are non-service-connected cases, although the AMA states that, if the situation is figured on the basis of patients discharged, the proportion of non-service-connected cases would probably go as high as 80 per cent.

### FIVE ACTIVITIES RECEIVE CUT

**The Department of Health, Education and Welfare plans to spend approximately $395,000,000 on health and medical activities this year, an increase of about $45,000,-000 over last year. Only five of the department's 28 major activities received a cut in budget in the past year. One of the most severe cuts was given to the Food and Drug Administration which acts to protect the public against adulteration and quackery by promoting the safety, purity, identity, potency, and the truthful and informative labelling of foods, drugs, cosmetics, and various appliances and related products.**

An interesting aspect of the Federal Government's expenditures in the health field is the operation of a federal employes health program under which certain federal agencies are authorized to operate health clinics to provide limited health service to federal workers. The program, authorized nearly 10 years ago, is designed to minimize illness and assist workers in remaining on the job.

Health services include treatment of on-the-job illnesses by a physician or nurse, pre-employment and fitness-for-duty examinations, and treatment for illnesses or conditions for which a worker is under the care of a private physician who, in turn, requests treatment for the patient at the federal clinic.

## *"Today's Health" Sets Circulation Record*

Chicago, Nov. 1.—With its October issue, *Today's Health* set a circulation record of over 340,000, the highest figure in its 31-year history of publication.

Promoting *Today's Health* is one of the major public health projects of the Wisconsin Woman's Auxiliary.

Last year, seven Wisconsin county auxiliaries were listed on the national "Today's Health Honor Roll" established by the national Woman's Auxiliary for those groups who obtained more than their assigned quota of subscriptions. These Wisconsin organizations included the following county auxiliaries: Langlade, 269 per cent; Rock, 165 per cent; Sheboygan, 160 per cent; Washington-Ozaukee, 155 per cent; Racine, 130 per cent; Kenosha, 126 per cent; and Brown–Kewaunee–Door, 101 per cent.

## Record Ratio of Doctors To Population Set

Chicago, Nov. 15.—A record low ratio of one doctor for every 730 persons in the United States was reached last year, according to figures recently released by the American Medical Association. The Council on Medical Education and Hospitals attributed the record ratio to the largest graduation class of physicians in history in 1953–54 and to school expansion.

Last year's graduation of 6,861 doctors brings the total physician population to approximately 220,100.

Ten new 4-year medical schools are scheduled to begin operation within the next five to six years.


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The only way you can be deprived of the time you need is in case of death or a long term disability.

TIME'S low-cost Income Continuance Plan is designed to provide a monthly income for the long term disability—with benefits beginning after 60 or 90 days of disability. It will be worth your time to learn the details.

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# WORLD HEALTH TERMED VITAL TO U. S. WELFARE

By CARL N. NEUPERT, M. D.

Many of the countries with major problems of starvation, disease and poverty have had them for centuries. We could be said to have our hands full *here at home.*

But can we disregard the pitiful lot of the millions in other lands who are starving for want of food, dying like flies of preventable disease and seeing one-half of their children die before the age of ten?

**We don't know how much time we have in which to help the less fortunate peoples to help themselves to better living but help them we must if we are to assure a safe, satisfactory, and fruitful world for our children, or even ourselves.**

The World Health Organization was born on April 7, 1948, when its membership had reached the total of 26 countries. There are now 84 member nations including 3 associate members and the iron curtain countries. It lends help in three major categories: health; agriculture and food; and education. A system of global reporting of communicable diseases is already operating. An international sanitary code has been established.

### IS COOPERATIVE HEALTH EFFORT

WHO is a specialized agency of the United Nations. Its role is that of directing and coordinating international health work. It is not a supra-national ministry of health, but rather a world-wide cooperative through which the nations help each other to help themselves in raising health standards.

The central office staff of WHO in Geneva, under direction of the Director-General, is made up of a professional and general staff from all over the world. Dr. M. G. Candau, the second Director-General, is from Brazil. His deputy is from France. There are a number from this country on the staff. There are five regional offices covering the globe.

The Director-General carries out whatever is authorized at the annual Assembly. The Assembly is the legislative body, comparable to our Congress, made up of delegates from each of the member countries, each country having one vote.

**The chief concern of the Sixth Assembly had to do with preventive aspects of health rather than treatment or welfare matters as we usually think of them. Let me stress here that actions taken by the Assembly are not automatically binding on the member countries. Each action is subsequently taken back to the individual country for adoption or rejection.**

**In our case, they are brought before the U. S. Senate, I believe.**

Dr. Neupert

These people in member countries of WHO have been living with their cultures and systems of government much longer than we, in most cases. We can't expect to impose our American system on them, precious as it is. But we *can* join with those of other countries in bringing technical knowledge to them. In providing technical assistance, the receiving country matches, usually many times over, the cost of the undertaking. Soon they proceed on their own so that this is not a continuing program of aid and subsistence in which the country becomes dependent on WHO, on us, or on the cooperating agencies.

Many countries provide personnel to make up the technical teams that go out. Last year there were 144 U. S. people in foreign countries in this work including 42 M.D.'s, 30 R.N.'s, 31 sanitary engineers, and 41 technicians. The problems, in many countries, currently require the training of more personnel and training them better, especially nurses, as the first objective in getting solutions.

**Dr. Thomas Parran, former Surgeon General of the U. S. Public Health Service and currently chairman of the National Citizens Committee for the World Health Organization, recently said that we are motivated to promote WHO in three ways: 1. Fear of epidemics; 2. Fear of war; and 3. Humanitarianism.**

We are not free from fear of epidemics of various types even in this country as yet, but many of the world's areas have them with them constantly. Fear of war *is* very much with us. Humanitarianism we have. If we ever lose that, we're lost as a people.

### WHO NEEDS OUR SUPPORT

I am going to risk possible disapproval by urging each of you to do some soul-searching to arrive at your own answer as to whether we have a stake in world health. Further, I appeal to you to back the World Health Organization. It's the best device I know of to put into practice in the field of health advancement some of our basic religious convictions and to avert war or the loss of our freedoms. It's an agency of the U. N. and the U. N. may have its shortcomings but it is still the best instrument to assure world peace.

**I have spent my life in Wisconsin and hope I can live and work here in the public interest the rest of my days—but not without due regard for the plight of the rest of the world in the interest of my fellow men and my family.**

Let me close with a plea to join many others over the country—solid, loyal people—as members of the National Citizens Committee for the World Health Organization. Its dues are $5 per year and it is doing a real service getting information to people. WHO needs our support. Our people live such busy lives, are subject to so many appeals, they may well overlook this very important one.

Whether you want to back WHO or not, can we agree our stake in world health is tremendous?

**In 1953, Dr. Neupert, who is State Health Officer, Wisconsin State Board of Health, served as a consultant to the United States delegation to the Sixth World Health Assembly held in Geneva, Switzerland.**

**This article is excerpted from a speech on "Our Stake In World Health," given by Dr. Neupert on October 28 at a meeting of the Wisconsin State Nurses Association.**

# Condemn "Defeatist Philosophy" At Medical Leaders' Meeting

St. Paul, Nov. 14.—"Physicians must never be deceived by the theory that government intervention for the wholesale solution of health economic problems can replace the orderly, sure progress of evolution," declared Dr. H. E. Kasten, Beloit, president of the North Central Medical Conference, at St. Paul, Minn., on November 14.

Presiding at a Conference meeting of nearly 75 officers of state and county medical societies from Wisconsin, Minnesota, Iowa, North Dakota, South Dakota, and Nebraska, Dr. Kasten charged that many physicians have "apparently resigned themselves to the threat of federally-controlled medicine."

**"They seem bewitched by the defeatist philosophy of 'peace at any price' and the delusion of 'coexistence,'" he said. "This seductive philosophy seems to have caused some staunch opponents of federally-controlled medicine to wonder if perhaps cooperation with the forces in Federal Government might not be the lesser evil."**

Dr. Kasten is a member of the Council of the State Medical Society. Also attending the meeting from Wisconsin were Dr. A. J. McCarey, Green Bay, president of the State Society; Dr. Ervin L. Bernhart, Milwaukee, president-elect; Dr. H. Kent Tenney, Madison, past-president; Dr. R. G. Arveson, Frederic, chairman of the Council; Dr. L. O. Simenstad, Osceola, speaker of the House of Delegates; Dr. W. D. Stovall, Madison, AMA delegate; and Dr. E. M. Dessloch, Prairie du Chien; Dr. N. A. Hill, Madison; and Dr. E. J. Hatleberg, Chippewa Falls.

Dr. Kasten

**Dr. Stovall participated in a panel discussion, "Do County and State Have Adequate Voice in Formulating AMA Policy?" and Dr. Simenstad served as a member of the Conference Nominating Committee for the election of officers.**

During his speech, Dr. Kasten said that he maintains an "undying belief that the art of medicine is still the master of medicine."

He pointed out, however, the difficulties of the practicing physician "constantly bedeviled by the threat of federal control" and facing not only scientific problems but also the "new and perplexing element of economics in health care."

"The doctor's position with his public is not improved when his brother physicians are divided against each other," he stated.

Dr. Stovall said: "Medicine is well organized to give expression to the views of the individual physician and society members. But if the individual physician won't read or do the research required to understand these problems, he cannot express adequately his opinions."

## Newspapers Supporting AMA Stand on Vet Care

Madison, Nov. 10.—Reports from the American Medical Association indicate that since the American Legion's national convention last August, more and more newspapers have come out in strong support of the AMA position on veterans' medical care.

A number of editorials and articles have shown a swing toward the principle that a veteran has earned federal medical care only if his illness is service-connected. This policy was adopted by the AMA House of Delegates at its meeting in New York in June, 1953.

Typical of the newspaper comment was an editorial in the October 8 edition of the *Wisconsin State Journal*, Madison, which stated, "We believe the AMA is right." It added, "the AMA has performed a service in bringing the issue out in the open."

## Name New Committee On Industrial Health

Madison, Dec. 13.—A new and permanent Committee on Industrial Health has been appointed by the State Medical Society to function as a part of the Council on Medical Services. Announcement of the appointment was made by Dr. D. E. Dorchester, Sturgeon Bay, chairman of the Council.

**Dr. Dorchester will serve as a member of the Committee. Other members are: Drs. E. L. Belknap, Milwaukee; T. S. Burdon, Green Bay; J. V. Flannery, Wausau; D. N. Goldstein, Kenosha; G. P. Gredler, Janesville; G. W. Petersen, Neenah; D. M. Ruch, Milwaukee; J. M. Wilkie, Madison; and R. S. Wright, Racine.**

Dr. Belknap was named chairman of the Committee when it held its first meeting December 11 in Milwaukee. Also attending the meeting were Harry Nelson of the Wisconsin Industrial Commission, and Miss Catherine Chambers and William Lea, Ph.D., from the Industrial Hygiene Unit of the State Board of Health.

Major responsibilities of the new Committee are the formulation of policy on pre-employment examinations and the revision of the booklet, "Industrial Health," which was published in 1948.

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# REP. LAIRD FEARS FEDERAL CONTROL THROUGH REINSURANCE

Government monopoly is a very distinct threat of the administration's health reinsurance program, according to Representative Melvin R. Laird, Marshfield, seventh congressional district.

Representative Laird's opposition to reinsurance was reported in the *Congressional Record* of July 13, 1954.

Mr. Laird's remarks before the House of Representatives are reprinted below:

**Mr. Laird.** I would like to state to the distinguished chairman of the Committee on Interstate and Foreign Commerce that I have read over the hearings conducted on this bill. I approve and support the administration's general health program, which places primary emphasis on the provisions of services and facilities for treatment of illness or injuries. It proposes diagnostic centers, specialized institutions for specific needs, medical facilities for rural areas, rehabilitation of disabled persons, improved income-tax treatment of medical expenses, and many more important features. Considering the entire health program, it can be said that it is sound and is generally aimed at those areas where the Federal Government should play a part.

### NEEDS CAN BE MET PRIVATELY

As to the reinsurance phase of the administration's health program, the administration should be congratulated for recognizing that the insurance needs of the Nation can be met by the private insurance companies and the various service plans. This is particularly true when contrasted with the Truman approach to the accident and health insurance needs of the Nation. I will vote against recommitting this bill, as there is no need for further study by the committee of this reinsurance plan. The plan should be defeated, and I will vote against final passage of the bill.

**There is no need for a Government reinsurance plan because:**

**First. The amount of risk in most plans can be easily assumed by the insurers. This is particularly true when compared, for instance, to the liability or fire field.**

**Second. Perhaps the need for reinsurance in this field is increasing, inasmuch as more companies are entering the major medical expense catastrophe field. Even here, however, there is no need, because reinsurance is available today from private sources. The committee has shown no case where a company large or small has been turned down on placing any reinsurance.**

**Third. In this connection, it should be stressed what reinsurance does and does not do. Reinsurance is not a panacea to the health problems of the Nation. It does not make insurance any cheaper. It does not make an uninsurable risk insurable. As a result of it, the medical indigent cannot be insured.**

### MONOPOLY A THREAT

The bill calls for the use of Federal reinsurance only in those cases where private reinsurance is not obtainable. Thus the argument has been made that the worst that can come of this is that Federal reinsurance will not be used. This is being politically naive. If the Federal reinsurance facilities are set up but not used, it is the nature of the Federal bureaucracy that efforts will soon be initiated to make this reinsurance work, to wit, competitive with private reinsurance. Once in competition, governmental monopoly is a very distinct threat.

The regulation for the companies requesting Federal reinsurance would be in the Federal Government. The bill gives the Secretary of Health, Education, and Welfare very broad powers in the regulation of the insurance companies. There are two criticisms to be made of this situation:

First. I question whether Congress should give any Cabinet member such broad powers to regulate a particular segment of private enterprise. I am aware that Congress cannot specifically spell out all details of the administration of the reinsurance bill, but I do think the bill could be more specific in an attempt to put some rein on the Secretary's activities.

Second. The Congress is on record as stating that the business of insurance shall be regulated by the various States. The States have done an admirable job in regulating the insurance industry. The regulatory aspects of the reinsurance bill are directly opposed to Public Law 15 of the 79th Congress which expressed the view that regulation of insurance should be in the hands of the various States.

Admittedly, there are certain "soft spots" of health insurance protection among groups of our population. Reinsurance will not cover these soft spots. Through experimentation the insurance industry is reducing these areas, for instance, retired employees, over age employees, rural people, individuals with physical or medical impairment, etc. However, the private insurance industry can never reach everyone. Thus, in these very limited areas there must be subsidies. In this connection, where subsidies must be made, the following safeguards should be made in the administration of the subsidy:

**First. The subsidy should be applied directly and openly.**

**Second. The subsidy should be administered at the local level.**

**Third. The subsidy should vary from State to State depending on the services available and the prevailing cost patterns.**

In conclusion, it should be stressed that voluntary insurance in the past 14 years has made tremendous strides. Currently, 100 million Americans have some form of hospital expense insurance, 75 million have surgical expense insurance and 40 million have medical—nonsurgical—expense insurance. As compared to 1940, the hospital insurance coverage has increased 6 times, the surgical expense insurance, 10 times, and the medical expense insurance about 40 times. Certainly there is every indication that this increase in insurance protection has not ceased. The optimism that prevails concerning the ability of the industry to meet the health expense protection of the Nation is well founded.

# CHICAGO APPROVES WATER FLUORIDATION

Chicago, Nov. 15.—The City Council of Chicago recently approved a measure which will institute flouridation of the city's water supply by January 1, 1955. The measure will affect about 3,600,000 Chicago residents as well as 500,000 in 51 suburbs.

Over 20,000,000 Americans are now served by water supplies fluoridated as a dental health measure. Flouridation is also being tested in other countries.

# ADMINISTRATION BOOSTS NEW REINSURANCE BILL

Madison, Nov. 1.—The administration's health reinsurance bill, defeated once, is getting renewed backing from President Eisenhower and Mrs. Hobby.

Of as much concern to the nation's physicians as the 25-million-dollar reinsurance program itself are the recent comments of both President Eisenhower and Secretary Hobby.

President Eisenhower, in an address October 21 in New York City, served notice that he would resubmit his health reinsurance plan to the next Congress and promised that it would be "an important part of the health program in the great gaps in the field of health."

#### HEW PREDICTS "BETTER" BILL

He added: "We are years behind our potential achievement in the availability and adequacy of health services."

His remarks on reinsurance came on the same day that Secretary Oveta Culp Hobby in one of her rare press conferences said that a department of HEW task force would soon have a "clear and better" bill to present to the President. Asked about objections of the AMA to reinsurance, Mrs. Hobby stated, "I hope very much that the AMA will see its way clear to support health reinsurance. We have the same objectives, the difference is only one of method."

Earlier in October, speaking before the Executives Club in Chicago, Mrs. Hobby was reported by The Chicago *Tribune* as saying that "one of the cardinal principles of the Eisenhower administration is that community and state levels of government are best equipped to handle matters which are essentially local in nature." Mrs. Hobby added that "health insurance was a field for the Federal Government."

#### AMERICANS WANT PROTECTION

In another meeting on October 11 before the American Life convention in Chicago, Mrs. Hobby sounded a warning that "it is apparent that the American people are going to have protection against health risks. I am convinced that the insistent and increasing demands of the people will one day be reflected by Congressional action of some sort. It is our joint task to help assure that the action taken will reflect the majority viewpoint of the American people who want voluntary health insurance."

She added: "We still strongly believe in a bill which seeks to compress the experimentation of the next 20 years into less than half the time through the simple mechanism of a broad sharing of risks. We believe such a bill would nurture rather than weaken the voluntary health insurance concept."

"I cannot state to you too strongly my belief that time is running against those who seek to keep health insurance on a voluntary basis," Mrs. Hobby warned.

The American Medical Association opposes reinsurance on the following grounds: (1) The insurance carriers themselves have all the reinsurance money needed; (2) Voluntary health insurance is making "extremely rapid" progress without reinsurance; (3) Reinsurance would not make uninsurable risks insurable; (4) Without objectionable subsidy, reinsurance would not reduce the cost of insurance or "overcome the inertia of the unwilling buyer."

## Number of M.D.'s In Armed Services Has Been Reduced

Washington, D. C., Dec. 10.—There were 11,140 medical officers in the three military services last July 1, according to the Defense department.

This is 2,360 less than the same time in 1953. According to Defense Secretary Wilson, the ratio of physicians to troops on an over-all Defense department basis has been reduced to 3 per 1,000.

The Defense department has announced that it has no intention of asking for an extension of the "doctor draft" act scheduled to expire next July 1. After that date, the bulk of the military requirements will be met by nonveterans whose military service under the regular draft act has been deferred until completion of their medical training.

The Defense department poll of men currently in this group indicates that 50 per cent want an extension of their deferments to continue on in residency training, but the department says "it will be possible to defer only about 10 per cent."

The problem of obtaining more experienced and more highly trained officers currently is being studied by a special committee. It is working up a procurement and utilization program to be put into operation when the doctor draft expires.

The department expects Congress next year to enact a military medical scholarship plan which it hopes will be helpful in recruiting for the regular medical corps and for long-range assignments. Under this plan, physicians on completion of their training, would be liable for one year of active duty for each scholarship year.

Dr. Hardgrove

## Hardgrove Given Post In Diabetes Group

Madison, Dec. 1.—Dr. Maurice Hardgrove, Milwaukee, has been appointed to represent Wisconsin on the newly-formed Board of Governors of the American Diabetes Association. The appointment came when the association's Council established the Board, composed of a representative from each state, to stimulate interest in diabetes and related conditions and to coordinate nation-wide activities.

Dr. Hardgrove is now the president of the Wisconsin Diabetes Association. He has been active in State Society programs and has served as president and member of the board of directors of the Milwaukee County Medical Society.

Among the Reference Committees meeting during the Eighth Clinical Session of the American Medical Association in Miami, Fla., was the Reference Committee on Medical Education and Hospitals shown here during its session on November 30. Dr. Dexter H. Witte, Milwaukee, a Wisconsin delegate serving on the Committee, is seated at the right end of the table. The Clinical Session was held November 29 to December 2, in Miami's McAllister Hotel.

# VA Okays Rx Use of Dressings For "Home-Town" Veteran Cases

Madison, Dec. 1.—Physicians caring for veterans under the "home town" VA care program may now prescribe certain dressings under certain conditions, it is reported by Dr. J. S. Supernaw. Madison, chairman of the Operating Committee of the Wisconsin Veterans Medical Service Agency of the State Medical Society of Wisconsin.

**Advice received from the Milwaukee Regional Office of the Veterans Administration indicates that gauze bandages, sterile pads, adhesive tape, and sterile absorbent cotton may be authorized "for use only in connection with the application of medication prescribed for immediate needs following an authorized treatment." They are not intended for prolonged continuing use in chronic cases.**

"They may be furnished on prescription only when such prescription is accompanied by a properly documented prescription for medication requiring the use of such accessory items for application as prescribed," according to the Veterans Administration.

At the same time, the Veterans Administration announced that it has amended its regulations concerning the provision of medical requisites on prescription.

Medical requisites are defined to include only the following items:

1. **Insulin syringe and two (2) needles**
2. **Two (2) hypodermic (insulin type) needles**
3. **Atomizer**
4. **Nebulizer**
5. **Hot water bottle**
6. **Fountain syringe**
7. **Combination hot water bottle and syringe**
8. **Ice bag**
9. **Ice cap**
10. **Urinal**
11. **Bed pan**
12. **Enema can**
13. **Feeding tube**
14. **Ear and ulcer syringe**
15. **Urethral catheter**

According to the VA, these medical requisites "will be supplied only on the original written prescription of a physician, dentist, or osteopath and will bear the same information and authorization statement as required for prescriptions of medication."

**Have You Returned Your AMA DIRECTORY INFORMATION CARD? If Not—Do It Soon!**

## Wisconsin SAMA Leaders Serve National Council

Madison, Nov. 10.—Representatives of both Wisconsin chapters of the Student American Medical Association are serving on the national organization's 6-member Executive Council this year, according to the reports of the State Medical Society's advisors to the local SAMA chapters at Marquette and the University of Wisconsin medical schools.

David J. LaFond, Marquette, and Eugene L. Weston, University of Wisconsin, are SAMA executive councilors. LaFond was national vice-president of SAMA last year and both are past presidents of their local chapters.

The reports were presented to the House of Delegates at its annual meeting in Milwaukee in October, by Dr. Joseph S. Devitt, Milwaukee, advisor to the Marquette chapter, and Dr. C. G. Reznichek, Madison, the University of Wisconsin chapter's advisor.

Also outlined in the reports were details of considerable organizational growth in both chapters, as well as the active programs they have developed.

The reports of the Society's advisors urged further cooperation between the State Society and the SAMA chapters, which serve as a training ground for future medical leaders. Special arrangements were made to allow SAMA members to attend the SMS annual meeting.

## Auto Toll Reaches Frightening Proportions, Society Reports

**Madison, Dec. 3.—Unless something is done immediately to prevent highway accidents from going beyond their present "frightening proportions," they "threaten to offset the achievements of medicine and public health during the past half century," the State Medical Society has declared.**

The warning was sounded in a resolution adopted at the second session of the Society's House of Delegates during the annual meeting in Milwaukee. The Society commended those responsible for the planning of the Governor's Conference on Highway Safety held in Milwaukee on October 1 and urged that it become an annual event.

*(Continued from page 682)*

An evaluation of these meetings in terms of service to members is rather difficult. Those attending have expressed sincere appreciation for the opportunity to attend teaching programs without undue loss of time from practice. The slackened interest shown may reflect a need for temporary curtailment of the programs as conducted these past two years or the need for placing more direct responsibility upon participating agencies and "host" counties. While the greatest benefits accrue to members of the Wisconsin Academy of General Practice by providing them with formal teaching credits through local regional teaching programs, little direct responsibility has been assumed by the Academy office to secure active participation of its members. This has not been due to an unwillingness to assume such responsibility, but rather to an acceptance of the practice that all promotional activities would be carried out through the office of the State Medical Society. If these programs are to be continued, more direct responsibility should be assumed by the Wisconsin Academy if the programs have value to its members. Likewise, more active participation in promotion on the part of other affiliate agencies may stimulate greater participation on the part of physicians.

Based upon the experience of the past two years a modified schedule has been planned for the next six months by the Coordinating Committee on Postgraduate Education, representatives of the Council on Scientific Work, the two medical schools, the State Board of Health, the Wisconsin Academy of General Practice, the Wisconsin Heart Association, the Wisconsin Anti-Tuberculosis Association, the American Cancer Society, Wisconsin Division, and the Wisconsin Chapter of the American Arthritis and Rheumatism Foundation. They have taken into consideration the fact that the shift in Annual Meeting dates from October to May will not permit the continuance of the circuit teaching programs through the spring months. Meetings are scheduled as follows: October 27, Rice Lake; October 28, Antigo; November 10, Green Bay; November 11, Sheboygan; December 8, Fond du Lac; December 9, Wisconsin Rapids; January 19, Janesville; January 20, Dodgeville; February 16, Baraboo; February 17, Viroqua.

An impressive array of faculty members has been secured for these programs, and it is felt that they will meet a real need for the busy practitioner who cannot absent himself from practice for more than a day at a time. It is hoped that the report of the Council on Scientific Work to the House in May 1955 will reflect continued interest in the teaching programs offered the members.

### Hearing Conservation Clinics

In cooperation with the Wisconsin Safety Council, the State Board of Health, and the Wisconsin Manufacturers Association, a very successful series of meetings was conducted this past year for physicians and plant management. The major discussion was on hearing loss, and the State Medical Society had the pleasure of providing a special program for physicians and nurses which was well received by those in attendance. More than 600 persons attended the three meetings in Wausau, Oshkosh, and Racine with the State Medical Society in a position of leadership on the medical aspects of this important industrial health program.

### In-Plant Clinic

Prior to last year the Committee on Industrial Health, in cooperation with the Council on Scientific Work, had sponsored a series of in-plant meetings of physicians, industrial nurses, management, and insurance representatives. Because of the importance of the hearing conservation program less attention has been directed to the in-plant program the past two years. However, in cooperation with the Medical Society of Milwaukee County such meetings have been held in that area each year with the 1954 meeting using the Falk Corporation for the plant tour. Nearly 200 physicians, nurses, and representatives of industry attended the excellent scientific program which followed. Topics and speakers were as follows: "Twenty Years' Experience in Medical Control of Foundry Workers' Silicosis," O. A. Sander, M. D., Milwaukee; "Recurrent Hernia —Repair with Skin Implants," G. S. Flaherty, M. D., Milwaukee; "Importance of the General Practitioner In Part-Time In-Plant Medical Program," Charles F. Shook, M. D., Toledo, Ohio; and "Hazards in the Use and Formulation of Insecticides," Frank Princi, M. D., Cincinnati, Ohio.

### Cancer Clinics

The detailed report of the scientific programs planned for physicians and dentists in cooperation with the American Cancer Society, Wisconsin Division, is provided through the report of the Committee on Cancer. Suffice it to say that these programs, as planned, with the approval of the Council on Scientific Work, have made a significant contribution to the scientific report for the past year and suggest further development during the next six months. The quality of the programs was high, attendance on the part of physicians and dentists alike was good, and resulting fine interprofessional relationships were evident. The Committee on Cancer is to be commended for the initiation of these programs, and the Council on Scientific Work welcomes their further development.

### The Annual Meeting

The Annual Meeting is, of course, the final and major effort of the Council on Scientific Work. Believing that only the best is good enough for our members, no efforts have been spared to provide a high quality scientific program. Speakers from all parts of the country are coming to Milwaukee to contribute to the program, and it is the hope of the Council on Scientific Work that they will feel repaid through attendance and interest shown in their presentations. The Council on Scientific Work knows that attendance at the various sessions of the House of Delegates and appearances before reference committees are time-consuming and by necessity direct attention away from the scientific programs. It is hoped, however, that delegates will make a special effort to participate in the scientific programs offered and through their active participation in the discussions help to make the 1954 meeting a success.

Because the 1955 meeting is to be held in May, the Council on Scientific Work has nearly concluded the program planning. Instead of teaching demonstrations there will be panel discussions on many basic subjects, and more emphasis will be placed upon general meetings.

While every effort has been made to provide a variety of teaching programs, both in connection with the Annual Meeting and with the other types of programs offered throughout the year, the Council on Scientific Work will welcome suggestions as to changes which can be made to provide an even better type of program for our members. When possible, these suggestions will be incorporated into future programs.

### *The Wisconsin Medical Journal*

This report would be incomplete without a word of deserved recognition to our medical editor of *The Wisconsin Medical Journal*, Robert S. Baldwin of Marshfield. Doctor Baldwin is a medical editor in the real sense of the word and devotes long hours to a close evaluation of medical articles submitted. His judgment as to what should and should not be included has resulted in an unusually fine scientific section of our state publication. Special mention should also be made of the contributions made by the pathologists of the state in providing material of great interest in this field. The Council on Scientific Work wishes to express thanks to all the contributors this past year and to commend Mr. Crownhart and his staff for the excellent manner in which this material is presented. While not directly within the province of the Council on Scientific Work, mention should be made of the many helpful nonscientific articles in the "Blue Book" and other issues, which make *The Wisconsin Medical Journal* one of the finest state publications in the country. It is recognized that the publication of this monthly magazine is no small task, and it is felt by the Council that the House should pay special recognition to the editor and his assistants for the splendid work they have done this past year.

### Summary

This past year's program consisted of 15 general scientific programs as part of the circuit teaching clinics; three hearing conservation clinics; one inplant industrial health clinic; five cancer clinics for physicians and dentists; and two conferences for physicians with school personnel at state colleges. Such a wide span of program planning and promotion has placed a considerable amount of work on the State Medical Society staff, but it has provided an avenue through which many physicians could keep abreast with new developments in medicine and also assume roles of leadership in many health programs of direct concern to lay groups. It is felt that the program this past year had real value to the members of the Society and at the same time placed the Society in a position of recognized leadership in many important areas of related medical practice.

The Council on Scientific Work wishes to express its appreciation to the House and to the Council, through its Audit and Budget Committee, for its continued fine support and approval of programs which have been developed to date. Care has been taken in the expenditure of funds, and without exception the Council on Scientific Work has been able to operate within the limit of funds provided. Also, special thanks should be extended to the State Board of Health for its generous support of many scientific programs offered, which has materially assisted with the development of programs within the budget limits provided.

### Future Planning

During the ensuing year it is hoped that the full complement of circuit teaching programs can be carried out as planned, that cancer clinics for dentists and physicians can be continued, and that special programs such as those on medical aspects of mental deficiency can be developed in cooperation with the State Department of Public Welfare and other agencies. The Council on Scientific Work is pleased to note that further school health conferences are being planned and will welcome the opportunity of reviewing other types of scientific programs as their need arises.

### Recommendation

The only recommendation to place before the House is that physicians should be encouraged to participate in all types of programs presented within their areas of the state and should make a special effort to participate in the Annual Meeting of the State Society. The efforts of the Council on Scientific Work will be amply repaid if members participate and assist with future program planning through their notes of approval or constructive criticism.

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On motion of Doctor Carlson, seconded by Dr. E. W. Humke, Chilton, carried, this section of the report was accepted with appreciation of the House of Delegates to the Council on Scientific Work for its efforts in advancement of scientific knowledge and direct service to the membership.

## COMMISSION ON STATE DEPARTMENTS

### DIVISION ON CRIPPLED CHILDREN

On motion of Doctor Carlson, seconded by Dr. L. E. Holmgren, Madison, carried, approval of the recommendations made by the Division on Crippled Children was expressed by the House.

### DIVISIONS ON GERIATRICS AND PUBLIC ASSISTANCE

On motion of Doctor Carlson, seconded by Dr. W. D. Stovall, Jr., Brodhead, carried, the reports of the Divisions on Geriatrics and Public Assistance were accepted.

### DIVISION ON MATERNAL AND CHILD WELFARE

Doctor Carlson then called upon Dr. Robert Purtell, Milwaukee, chairman of the Division on Maternal and Child Welfare, who expressed his appreciation to the members of his Division for their difficult background work in preparing the Division's report. He also thanked Dr. T. A. Leonard and his Maternal Mortality Study Committee for their efforts and Dr. Amy Louise Hunter of the State Board of Health for her cooperation in gathering statistical data.

The reference committee recommended that the Maternal Mortality Study should be continued for the ensuing year, with thought given at the end of that time to whether the study should be carried on for a further period.

The committee also concurred with the opinion of the Division that further development of institutes for the care of the premature infant should be achieved. Every hospital which has not participated in such an institute should be encouraged to do so by selecting one physician and one nurse to form a team for an instructional course.

A resolution was introduced by the reference committee as follows:

WHEREAS, The Division on Maternal and Child Welfare has recommended that every hospital staff and county medical society meet during this coming year, at which time a member of the Study Committee or one of the assisting interviewers can present the findings and conclusions of the Maternal Mortality Study;

THEREFORE, BE IT RESOLVED, That a copy of this resolution be submitted to the chief-of-staff of each hospital, urging that at least a portion of a meeting or an entire meeting of the hospital staff be set aside for this purpose.

On motion of Doctor Carlson, seconded by Dr. R. H. Bitter, Oshkosh, carried, this section of the report was accepted.

## DIVISION ON NERVOUS AND MENTAL DISEASES

In considering the report of the Division on Nervous and Mental Diseases, the reference committee directed special attention to the report of the Subcommittee on Clinical Pathologists. It recommended that whatever policy is established should coincide with the policy of the Committee on Mental Health of the AMA as this committee has been studying the problem on a national level. The reference committee was of the opinion, however, that this group should not be licensed but rather should be certified by its own group.

The reference committee recommended that the report of the Subcommittee on Commitment Laws be approved and be referred to the Committee on Public Policy for implementation. It also suggested that local county medical societies should recommend to the judges or others empowered in commitment procedures the proper fees for examination of these patients.

The reference committee recommended that authority be given the Division on Nervous and Mental Diseases to assist the director of mental hygiene of the Department of Public Welfare and his staff in the development of a manual to be made available to those medical directors of county hospitals desiring it.

The committee concurred with the recommendation of the Division that the Committee on Public Policy consider sponsoring additional legislation which will change the statutes so that no longer will it be a requirement to report epilepsy to the State Board of Health.

The reference committee recommended that the Division on Nervous and Mental Diseases give further thought to the proposal to develop traveling teams of psychiatrists who could travel around the state and aid the general practitioner, particularly in the rural areas.

In conclusion, the reference committee concurred in the recommendation of the Division on Nervous and Mental Diseases that a special study group be created to evaluate the problems of alcoholism and give medical guidance where indicated.

It was moved by Doctor Carlson, seconded by Dr. W. D. Stovall, Jr., Brodhead, that this section of the report be accepted.

At this time Dr. J. M. Sullivan, Milwaukee, chairman of the Committee on Public Policy, pointed out that the last section of the report was almost a mandate to the Committee on Public Policy to have certain laws enacted. He stated that he was in favor of every recommendation in the report but suggested that Doctor Carlson's motion be amended so as to give the Public Policy Committee a little leeway in implementing the legislation.

Doctor Carlson agreed to include that provision in his motion; and, when put to a vote, the motion carried unanimously.

## DIVISION ON VISUAL AND HEARING DEFECTS

In considering the report of the Division on Visual and Hearing Defects, the reference committee recommended that the Division be commended for the development of the pamphlet entitled, "Hearing Conservation Programs for Wisconsin Industries," which serves as a guide to assist management with the formulation of a hearing conservation program. The Division was urged to continue development of suitable standards for a visual screening program which would be patterned on the same basic principles as the hearing program.

On motion of Doctor Carlson, seconded by Dr. K. L. Bauman, Lancaster, carried, this section of the report was accepted.

## DIVISION ON REHABILITATION

On motion of Doctor Carlson seconded by Dr. K. L. Bauman, Lancaster, carried, the report of the Division on Rehabilitation was accepted.

## DIVISION ON SCHOOL HEALTH

The reference committee commended the Division on School Health for development of its Conferences on School Health and encouraged development of further programs as a means of bringing together school people, physicians, nurses, and parents to study problems of common interest in respect to the physical aspects of child growth. The committee also agreed with the recommendation that continued cooperation should be given the Wisconsin Interscholastic Athletic Association so that all medical aspects of this program would be in line with sound medical practices and in the best interests of the children covered.

On motion of Doctor Carlson, seconded by Dr. R. H. Bitter, Oshkosh, carried, this section of the report was accepted.

### DIVISION ON TUBERCULOSIS AND CHEST DISEASES

On reviewing the report of the Division on Tuberculosis and Chest Diseases the reference committee recommended that the State Medical Society's efforts be directed toward assisting the tuberculosis detection program of the State Board of Health in any way possible. In this connection, the reference committee commended the Wisconsin Welfare Council for taking the initiative in providing an extensive screening program for migrant workers. It also emphasized the importance of institutional care for tubercular patients and urged that efforts be made in all areas to set up a workable chest examination program for school personnel so that school children and others in contact with school employees would be assured protection.

The reference committee also agreed with the recommendation that the State Medical Society should lend its support to the securing of state funds for the proper operation of the Douglas County Sanatorium for the Mentally Ill as a specialized facility. The Department was also urged to explore avenues for the care of selected patients where closer psychiatric supervision is possible.

On motion of Doctor Carlson, seconded by Dr. P. B. Blanchard, Cedarburg, carried, this section of the report was accepted.

### COMMITTEE MEMBERS COMMENDED

The reference committee recommended that the House commend all committee members for their noteworthy efforts in behalf of the Society. The hours spent in going to and in attendance at meetings, and the interest and devotion of these men to these duties merit particular commendation.

On motion of Doctor Carlson, seconded by Dr. E. C. Cary, Reedsville, carried, this section of the report was accepted.

## SUMMARY REPORT TO THE MEMBERSHIP

Doctor Carlson stated that the reference committee had discussed how the membership at large could best be advised of the transactions of this House of Delegates. As a result, the committee recommended that a summary report be prepared and mailed to each member of the Society as soon as possible after the meeting of the House of Delegates. It was felt that greater interest in the affairs of the Society would result when all members are reached in this way. The reference committee further recommended that similar information be sent to the press of all communities in the state. Secretaries of county societies were asked to refer these matters to their appropriate committees for consideration and action.

On motion of Doctor Carlson, seconded by Dr. R. L. MacCornack, Sr., Whitehall, carried, this section of the report was accepted.

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On motion of Doctor Carlson, seconded by Dr. R. H. Bitter, Oshkosh, carried, the report of the Reference Committee on Standing Committees, as a whole, was adopted.

# REPORT OF THE REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS

Dr. T. W. Tormey, Jr., Madison, chairman, presented the report of his committee, which was composed of Drs. J. A. Enright, Milwaukee; H. A. Aageson, Oconto; W. C. Henske, Chippewa Falls; E. D. Sorenson, Elkhorn; and J. D. Leahy, Park Falls.

## RESOLUTIONS ON ANNUAL MEETING

Four resolutions concerning arrangements for the Annual Meeting to be held in the spring of the year were recommended for adoption. On motion of Doctor Tormey, seconded by Dr. A. A. Quisling, Madison, carried, this section of the report was accepted.

## SECTIONS ON UROLOGY AND PUBLIC HEALTH

The reference committee recommended adoption of the resolutions to create the Sections on Urology and Public Health. It reported its understanding that a special study would be made in the ensuing months with reference to the establishment of Sections in such manner that their existence does not conflict with the legislative organization of the House of Delegates.

On motion of Doctor Tormey, seconded by Dr. H. A. Aageson, Oconto, carried, this section of the report was accepted.

## REPORTS OF THE COMMISSION ON PREPAID PLANS

The reference committee was of the opinion that the House should express strong commendation to the Council and to the Commission on Prepaid Plans for their recognition of the fact that all essential developments and projects in the prepaid fields must be made known to the physicians of this state in advance of any final action. It believed that the supplementary report presented by Doctor Tenney was strong evidence of the leadership of the State Medical Society of Wisconsin in this whole field. The committee recommended that supplementary report for adoption and further that special problems encountered by the prepaid plans in the national field must be handled quickly and in full knowledge of current details. It, therefore, asked that the House express its full confidence in the discretion and judgment of the Council and the Commission on Prepaid Plans as these matters arise.

On motion of Doctor Tormey, seconded by Dr. O. E. Satter, Prairie du Chien, carried, this section of the report was accepted.

## COMMITTEE ON GRIEVANCES

R. E. Fitzgerald, chairman; E. W. Mason; F. A. Nause; C. E. Zellmer; E. D. Sorenson; H. W. Wirka; C. D. Neidhold; C. B. Hatleberg; J. L. Moffett.

The report of the Grievance Committee, as published in the *Handbook for Delegates*, follows, with the exception of the Interprofessional Code, which will be printed in full when finally determined:

The work of the Committee on Grievances over the past five years has demonstrated the value of its activities as an implement for bettering public relations. With each year the work of the committee has increased so that there have been not only more demands on the time of the committee members but also, and to a far greater degree, there have been demands on the time of our secretary and his assistants. In most instances it is they who have done the investigating which is necessary whenever a grievance is under consideration since it must be obvious that the members of the profession who comprise the committee would not have the time or facilities to delve deeply into the issues which arise when a case is brought to the attention of the committee. It follows that the Committee on Grievances is making a greater demand each year on the finances of the Society, and this fact should be recognized when the budget is drawn up. Since the benefit of the activity of this committee is to the profession as a whole, as well as to the public, the question of adequate funds for financing should be given careful consideration.

Along with two major projects, namely (1) A liability insurance plan and (2) the formulation of an interprofessional code, there have been a goodly number of cases involving individual physicians and laymen. Some complaints concerned the matter of professional charges, and virtually all of these have been adjusted. Some lacked any merit at all, and others indicated what amounted to an unawareness on the part of the patient as to the extent of the services that had been provided him. A small number of complaints involved individuals who apparently sought further assurance that the advice they had received or the work that had been done was appropriate to their condition. As might be expected, some complaints emanated from individuals whose mental attitude had suffered because of some long-time affliction. They are "chronic complainers."

### Liability Insurance

Several years ago the House of Delegates instructed this committee to make a study of liability insurance held by physicians in Wisconsin to ascertain whether there were means of providing this insurance more effectively than was then the case.

The committee has carried out its assignment to the best of its ability; it has held conferences with officials of other state medical associations interested in the same problem; it has reviewed the possibility of a group program; and it has met with insurance company officials.

As this House is aware, the same subject is being studied by the American Medical Association and by some of the larger state medical associations.

The committee believes that with a membership the size of that in Wisconsin, a group program is not feasible; it further believes that the entire membership would not be interested in a group program, but that many would prefer to carry their insurance as at present. A group plan would involve a considerable amount of work and expense on the part of the Society itself. Generally speaking, group insurance requires that a major percentage of the members be enrolled; and as long as that percentage is retained, the danger of cancellation is minimal, and there can be no cancellation as to the individual himself. But maintenance of the enrollment requirements would obviously be a responsibility of the Society, and constant efforts would become necessary in that direction.

The House should be aware also that the market for this type of insurance is not a sizable one, all of which contributes to the conclusion of this committee that Wisconsin should defer any further action on this subject until a report is forthcoming from the national organization. The committee has developed one or two proposals that might be considered and will transmit them to the national group; but as of this writing, the committee has tabled the study and asks the approval of the House to that action.

### Interprofessional Code

A long-time project of this committee is nearing completion. There have been a number of conferences and two joint meetings with representatives of the Wisconsin Bar Association, the first of which was held in February of 1952.

The project really arises out of a report filed by the Grievance Committee some years ago and which met with approval of the House of Delegates. The effect of that report was to provide a mechanism for the review of expert medical testimony claimed to be inaccurate or insufficient. The Grievance Committee during this current year had one such case referred to it; and following the procedure approved by the House, a certified copy of the testimony was obtained at Society expense. The testimony was mimeographed and made available to each member of the committee; and two committee sessions were held, during which this matter and others were considered. The member of the Society against whom the complaint was made was interviewed by the committee and the end result, which is not the point of this report, but which should be described to the House, was the committee's judgment that the physician had erred in good judgment as to the content of his testimony, but that such error was due to the fact that the examination was conducted by an attorney who had not had the advantage of any pre-trial conference with the physician concerned.

This one case is an example of the necessity of developing a formal recognition of problems existing between attorneys and physicians with reference

to the subject of medical testimony, either by physicians in attendance or those qualified as experts.

Following the several conferences mentioned, and draft and redraft of the proposed Interprofessional Code, it has been circulated to physicians and attorneys who have had trial experience and can view the Code from a wealth of background. For the most part all suggestions received have been constructive and pertinent, and to the best of its ability the report now is very near final form. Its circulation to the delegates will cause its circulation to the entire Society membership. It may well be anticipated that this draft will be somewhat modified or extended, and it is certain that a further conference with representatives of the Wisconsin Bar Association will be necessary before the Code can be circulated with the endorsement of the State Medical Society and the Wisconsin Bar Association.

One word of caution: To those who have experienced years of practice in either profession, portions of the Code may seem superficial or so fundamental that they should not be included.

However, this Code, while intended to clarify certain areas of difficulty which exist between members of the two professions, is also intended to bring about in the years which follow a basic understanding of some of these problems by those who are entering upon the practice of law or medicine for the first time. It is known to physicians that medical education imposes overwhelming demands upon teacher and student alike in its purely scientific aspects. Practical problems of medical practice in their economic and social sense may not be touched upon at all during the course of medical education, or so little time given them that the new licentiate is fully conscious of some of these problems only after he enters active practice.

Much of what has been said about medical education also characterizes the education of the law student. In the course of experience with this Code it will doubtless be found that there are ramifications yet to be explored and revisions indicated which are not apparent at this time. But the Code has for its purpose the long-range project of providing, as a joint responsibility of the State Medical Society of Wisconsin and the Wisconsin Bar Association, material which will tend to eliminate areas of difficulties and which will, the committee hopes, clarify for the new practitioner matters of which he would be almost entirely unaware until he actually encountered them as problems in his practice, either of law or of medicine.

The committee suggests to the House that it endorse in principle the Interprofessional Code as submitted to delegates, with the understanding, however, that some further revisions may be necessary. The committee and the Council should be given that authority in the adoption of this report.

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In the committee's 1953 report it was indicated that if the House of Delegates approved, the committee would review the cost and staff impact of its activities in the eight-month period from November 1, 1953, to June 30, 1954. The purpose was to consider the feasibility of reporting this cost annually with the thought that the House of Delegates at some future date should consider levying a retrospective assessment on the membership as a whole.

The responsibilities of carrying on the duties of this committee effectively and in sufficient detail to enable it to secure all pertinent information call for a very considerable amount of traveling, correspondence, and telephone calls. Records are specially maintained in locked cabinets to which only a limited number of the staff have access. All this activity, which has persisted in varying degrees the last three years, has been accepted by the profession as its responsibility. However, there has been no specific provision to implement it. There has been no increase in staff facilities, and extra work has been added to the duties of a staff which already appears to have something more than an eight-hour day and a 40-hour week, as must be within the knowledge of the delegates themselves.

In the eight-month period ending June 30, 1954, administrative expense was in excess of $3,300. To this may be added approximately $1,800 related to the time of the secretary in handling cases and conferring with committee members and similar expense in direction of the over-all project. This could be further detailed, but the substance is that current activities of this committee have totaled an annual expenditure of six or seven thousand dollars. Had the work been carried on at a somewhat faster tempo and in further detail, both of which the committee believes advisable, it is estimated that the year 1953–54 would have cost a total of $10,000. Since it is evident that the benefit of the activities of the Committee on Grievances accrues to all members of the profession, the committee recommends to the House of Delegates that the question of implementing the work of the committee be discussed with the local county societies for their general consideration of the financial problem, and that the matter be discussed again at the time of the 1955 meeting.

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The reference committee was satisfied that the work assigned to the Committee on Grievances requires special budgetary consideration. In 1955 specific details of costs will be reported to the House of Delegates, and in advance of that meeting, to county societies, so the problem of financing further activities of the Grievance Committee will be discussed at that time.

The reference committee recommended that the House of Delegates approve the Interprofessional Code in principle, recognizing that further refinements may be necessary and that the Council and the Grievance Committee have final authority with reference to those details.

The reference committee also suggested that a communication be sent to the officers of the Wisconsin Bar Association expressing appreciation for the splendid cooperation of the Association in the notable effort of the two professional groups in developing the Code.

On motion of Doctor Tormey, seconded by Dr. D. N. Goldstein, Kenosha, carried, this section of the report was accepted.

## RESOLUTIONS ON GOVERNOR'S CONFERENCE, TODAY'S HEALTH, AND NATIONAL NURSE WEEK

On motion of Doctor Tormey, seconded by Dr. R. J. Bryant, Durand, carried, these resolutions were adopted by the House.

## RESOLUTION ON JOURNAL ADVERTISING

The following resolution, submitted by Dr. S. D. Beebe, Sparta, was distributed to delegates with the *Handbook for Delegates:*

WHEREAS, The Board of Trustees of the American Medical Association now prohibits the advertising of any alcoholic beverages (including beers, wines, and so-called hard liquors) in *The Journal of the American Medical Association* or any of its nine specialty journals or in *Today's Health,*

THEREFORE, BE IT RESOLVED, That the advertising of any of the above-named alcoholic beverages be prohibited in *The Wisconsin Medical Journal.*

The reference committee stated that under the Constitution and By-Laws this clearly falls within the management responsibilities of the Council, and it recommended that the resolution be forwarded to the Council without recommendation of the House.

On motion of Doctor Tormey, seconded by Dr. R. L. MacCornack, Sr., Whitehall, carried, this section of the report was accepted.

## DUES FOR 1955

With reference to dues for 1955 the committee was interested in the fact that accounting devices are being established so that direct and indirect costs of major projects of the Society can be determined with accuracy. The committee was advised that over a period of time this material would be available in the future consideration of the financial structure and the annual budget of the Society. The committee was satisfied, however, that the activities of the Society are being carried on with care and with close attention to detail. It recommended that dues for 1955 be continued at $60.

On motion of Doctor Tormey, seconded by Dr. G. W. Carlson, Appleton, carried, this section of the report was accepted.

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On motion of Doctor Tormey, seconded by Dr. M. D. Davis, Milton, carried, the report of this reference committee, as a whole, was adopted.

## COMMITTEE AUTHORIZED TO MEET WITH AMERICAN LEGION

Dr. E. C. Cary, Reedsville, asked the privilege of the floor to present a motion. He stated that there apparently is a great deal of misunderstanding between the American Medical Association and the American Legion over the care of veterans. He then presented a motion that the president of the Society appoint a liaison committee of three or five members to meet to discuss the matter with a like committee to be appointed on October 9 by the state commander of the American Legion.

The motion was seconded by Dr. W. D. Stovall, Jr., Brodhead, and carried, but not unanimously.

## Adjournment

The second session of the House of Delegates adjourned at 9:00 p.m.

# THIRD SESSION

## Wednesday, October 6, 1954

The third session of the House of Delegates convened at 8:40 a.m., Dr. L. O. Simenstad, Speaker, presiding.

## Report of Committee on Credentials

The Committee on Credentials verified the registration of 51 delegates and seven alternate delegates entitled to vote at this session of the House of Delegates.

In addition, five alternate delegates and four councilors registered their attendance.

On motion of Dr. J. W. Fons, Milwaukee, seconded by Dr. E. C. Cary, Reedsville, carried, the attendance roll of delegates and alternate delegates totaling 58 was accepted as the official roll of this session of the House to stand for the entire session.

## Report of Committee on Nominations

Dr. E. C. Cary, Reedsville, chairman of the Committee on Nominations, presented the names of the following nominees for official positions in the State Medical Society:

For President-Elect: Dr. Ervin L. Bernhart, Milwaukee;

For Speaker of the House: Dr. L. O. Simenstad, Osceola;

For Vice-Speaker of the House: Dr. J. W. Fons, Milwaukee;

For Delegate to the AMA to succeed Dr. S. E. Gavin: Dr. S. E. Gavin, Fond du Lac;

For Delegate to the AMA to succeed Dr. D. H. Witte: Dr. D. H. Witte, Milwaukee;

For Alternate Delegate to the AMA to succeed Dr. L. O. Simenstad: Dr. L. O. Simenstad, Osceola;

For Alternate Delegate to the AMA to succeed Dr. J. C. Griffith: Dr. J. C. Griffith, Milwaukee.

Milwaukee was the choice for the place for the next Annual Meeting of the Society.

On motion of Dr. A. A. Quisling, Madison, severally seconded, and carried, Doctor Bernhart was unanimously elected to the office of president-elect.

Dr. J. W. Fons, Milwaukee, vice-speaker, assumed the chair.

On motion of Dr. E. C. Cary, Reedsville, seconded by Dr. O. E. Satter, Prairie du Chien, carried, Doctor Simenstad was unanimously re-elected Speaker of the House. Doctor Simenstad then resumed the chair.

On motion of Dr. R. L. MacCornack, Sr., Whitehall, severally seconded, carried, Doctor Fons was re-elected Vice-Speaker of the House.

On motion of Dr. G. N. Gillett, Racine, severally seconded, and carried, Doctor Gavin was unanimously re-elected delegate to the AMA.

On motion of Dr. D. N. Goldstein, Kenosha, severally seconded, and carried, Doctor Witte was unanimously re-elected delegate to the AMA.

On motion of Dr. R. L. MacCornack, Sr., Whitehall, severally seconded, and carried, Doctor Simenstad was unanimously re-elected alternate delegate to the AMA.

On motion of Dr. T. W. Tormey, Jr., Madison, severally seconded and carried, Doctor Griffith was unanimously re-elected alternate delegate to the AMA.

On motion of Dr. W. D. Stovall, Jr., Brodhead, severally seconded, and carried, Milwaukee was selected as the place for the 1955 meeting.

Speaker Simenstad appointed a special committee composed of Drs. E. C. Cary, Reedsville; J. W. Fons, Milwaukee; and Charles W. Giesen, Superior, to escort the president-elect to the platform.

## Election of Councilors

The House then proceeded to the election of councilors, with the following results:

In the First District, Dr. W. D. James, Oconomowoc.

In the Second District, Dr. L. H. Lokvam, Kenosha.

In the Third District, Dr. H. E. Kasten, Beloit.

In the Eleventh District, Dr. V. E. Ekblad, Superior.

In the Twelfth District, Drs. R. E. Galasinski, E. L. Bernhart, and N. J. Wegmann, Milwaukee.

## Acceptance of the President-Elect

Dr. E. L. Bernhart was escorted to the platform by the special committee which had been appointed by the Speaker. In his speech of acceptance, Doctor Bernhart made the following remarks:

"For the first time in my life I am at a loss for words. However, I want to thank all of you for this fine recognition. I realize the challenge that goes with this honorable office; and I hope my physical stature, or what is left below the diaphragm, will be sufficient for me to do a job as capable as that of my predecessors.

"I know that, with the fine staff in Madison, and the grand bunch of councilors I have had the opportunity to associate with during the past three years, I will be able to do the job of keeping the State of Wisconsin at its very high level as far as the medical profession is concerned.

"I ask for your continued cooperation. I know I will have it. I hope your trust in me will be rewarded by a performance that will be to your satisfaction.

"Thank you very much."

## Adjournment Sine Die

The House of Delegates adjourned, *sine die*, at 9:15 a.m.

## UNIVERSITY OF WISCONSIN INSTITUTES RESEARCH UNIT FOR STUDY OF AMYOTROPHIC LATERAL SCLEROSIS

### Physicians Urged to Refer Patients for Evaluation

A research unit for the study of amyotrophic lateral sclerosis and allied disorders has been established at the University of Wisconsin Medical School. It is supported and financed by the Detling Foundation and is currently under the leadership of Dr. Peter L. Eichman. Participating in the study are: Dr. P. Settlage and graduate student R. P. Bunge in the Department of Anatomy, Dr. G. ZuRhein of the Department of Pathology, and Drs. Hans H. Reese and Henry A. Peters of the Department of Neuropsychiatry.

The primary purpose of the study is an advance in the knowledge of this clinical disorder, its possible etiologic mechanisms, and the use of the various therapeutic measures. Arrangements have been made for the evaluation of patients suspected of having this disease. Patients may be seen as outpatients for immediate evaluation, though admission to the hospital for detailed clinical studies is carried out in the usual manner for hospitalization to the University Hospitals at Madison 6, Wisconsin.

If you have patients with the spinal form with its muscular atrophy, fasciculations, and spastic weakness of the legs, without sensory disturbances, or the bulbar type with dysphagia, nasal speech, fasciculations of the tongue, and the like, we should be most interested in evaluating the syndrome as a part of our program of study for you. Full clinical reports will be sent to you following our examinations. With your cooperation we would also like to offer several types of treatment.

# Attendance at House of Delegates, Milwaukee October 4, 5, and 6, 1954

| Society | Delegate | Sessions 1 | 2 | 3 |
|---|---|---|---|---|
| Ashland–Bayfield–Iron | J. W. Prentice, Ashland | x | x | x |
| | J. M. Jauquet, Ashland* | a | a | a |
| Barron–Washburn–Sawyer–Burnett | N. A. Eidsmoe, Rice Lake | a | a | a |
| | W. B. Rydell, Rice Lake* | a | a | a |
| Brown–Kewaunee–Door | L. C. Miller, Green Bay | x | x | x |
| | P. F. Dockry, Green Bay* | a | x | a |
| | R. M. Waldkirch, De Pere | x | x | a |
| | S. L. Griggs, Green Bay* | a | a | a |
| Calumet | E. W. Humke, Chilton | x | x | a |
| | A. C. Engel, New Holstein* | a | a | a |
| Chippewa | W. C. Henske, Chippewa Falls | x | x | x |
| | J. J. Sazama, Chippewa Falls* | a | a | a |
| Clark | M. V. Overman, Neillsville | x | x | x |
| Columbia–Marquette–Adams | J. H. Houghton, Wisconsin Dells | x | x | x |
| | R. F. Inman, Montello* | x | x | x |
| | J. W. MacGregor, Portage* | a | a | a |
| Crawford | O. E. Satter, Prairie du Chien | x | x | x |
| | T. F. Farrell, Prairie du Chien* | a | a | a |
| Dane | L. E. Holmgren, Madison | x | x | x |
| | J. R. Steeper, Madison* | a | a | a |
| | M. T. Morrison, Mount Horeb | a | a | a |
| | J. A. Grab, Sun Prairie* | x | a | a |
| | T. W. Tormey, Jr., Madison | x | x | x |
| | R. N. Allin, Madison* | x | x | x |
| | C. W. Stoops, Jr., Madison | x | x | x |
| | R. F. Collins, Madison* | a | a | a |
| | G. C. Hank, Madison | x | x | x |
| | O. S. Orth, Madison* | x | x | a |
| | A. A. Quisling, Madison | x | x | x |
| | John T. Sprague, Madison* | x | x | a |
| Dodge | A. B. Kores, Beaver Dam | a | a | a |
| | L. W. Schrank, Waupun* | x | x | x |
| Douglas | Charles W. Giesen, Superior | x | x | x |
| | C. J. Picard, Superior* | x | x | x |
| Eau Claire–Dunn–Pepin | R. J. Bryant, Durand | x | x | x |
| | R. C. Strand, Eau Claire* | x | x | a |
| Fond du Lac | H. J. Kief, Fond du Lac | x | x | x |
| | J. S. Huebner, Fond du Lac* | a | a | a |
| Forest | E. F. Castaldo, Laona | a | a | a |
| | B. S. Rathert, Crandon* | a | a | a |
| Grant | K. L. Bauman, Lancaster | x | x | a |
| | J. W. Conklin, Platteville* | a | a | a |
| Green | W. D. Stovall, Jr., Brodhead | x | x | x |
| | D. E. Mings, Monroe* | a | a | a |
| Green Lake–Waushara | H. C. Koch, Berlin | x | x | x |
| | Roy Hong, Wild Rose* | x | a | a |
| Iowa | C. L. White, Mineral Point | a | a | a |
| | S. B. Marshall, Hollandale* | a | a | a |
| | W. D. Hamlin, Mineral Point* | x | a | a |
| Jefferson | F. A. Gruesen, Fort Atkinson | x | a | x |
| | Raymond W. Quandt, Jefferson* | a | x | a |
| Juneau | V. M. Griffin, Mauston | a | a | a |
| | J. S. Hess, Mauston* | a | a | a |
| Kenosha | D. N. Goldstein, Kenosha | x | x | x |
| | L. H. Lokvam, Kenosha* | a | a | a |
| La Crosse | R. L. Gilbert, La Crosse | a | x | x |
| | R. W. Ramlow, La Crosse* | x | a | a |
| Lafayette | L. L. Olson, Darlington | x | a | a |
| | R. E. Oertley, Darlington* | a | x | x |
| Langlade | F. H. Garbisch, Antigo | x | x | a |
| | C. E. Zellmer, Antigo* | x | a | x |
| Lincoln | R. G. Baker, Tomahawk | a | a | a |
| | K. A. Morris, Merrill* | x | x | x |
| Manitowoc | E. C. Cary, Reedsville | x | x | x |
| | R. G. Strong, Manitowoc* | a | a | a |
| Marathon | E. P. Ludwig, Wausau | x | x | a |
| | D. M. Green, Wausau* | x | a | x |
| Marinette–Florence | C. E. Koepp, Marinette | x | x | x |
| | J. W. Boren, Jr., Marinette* | x | a | a |
| Milwaukee | L. J. Ricciardi, Milwaukee | x | x | a |
| | H. J. Lec, Milwaukee* | x | a | a |
| | E. R. Daniels, Milwaukee | x | a | a |
| | E. P. Bickler, Milwaukee* | a | a | a |
| | F. E. Drew, Milwaukee | x | x | x |
| | G. E. Collentine, Jr., Milwaukee* | x | x | a |
| | J. W. Fons, Milwaukee | x | x | x |
| | J. E. Conley, Milwaukee* | x | a | x |
| | J. G. Garland, Milwaukee | x | x | x |
| | J. P. Conway, Milwaukee* | a | a | a |
| | J. V. Herzog, Milwaukee | x | x | x |
| | D. V. Elconin, Milwaukee* | a | a | a |
| | S. W. Hollenbeck, Milwaukee | x | x | x |
| | M. S. Fox, Milwaukee* | a | x | x |
| | W. J. Houghton, Milwaukee | x | x | x |
| | P. F. Hausmann, Milwaukee* | a | a | a |

*Alternate.

| Society | Delegate | Sessions 1 | 2 | 3 |
|---|---|---|---|---|
| | G. S. Kilkenny, Milwaukee | a | a | x |
| | G. W. Hilliard, Milwaukee* | x | x | x |
| | L. P. Stamm, Milwaukee | x | x | x |
| | R. L. Rice, Milwaukee* | a | x | a |
| | C. A. H. Fortier, Milwaukee | x | x | x |
| | J. M. Sullivan, Milwaukee* | x | x | x |
| | A. J. Baumann, Milwaukee | x | x | x |
| | R. A. Frisch, Milwaukee* | x | a | a |
| | J. B. Wilets, Milwaukee | x | x | a |
| | R. E. Callan, Milwaukee* | a | a | a |
| | R. F. Purtell, Milwaukee | x | x | x |
| | D. W. Ovitt, Milwaukee* | x | a | a |
| | J. A. Enright, Milwaukee | x | x | x |
| | S. L. Chojnacki, Milwaukee* | x | x | a |
| | P. J. Niland, Milwaukee | x | x | a |
| | A. D. Kilian, Milwaukee* | a | a | a |
| | P. E. Oberbreckling, Milwaukee | x | x | x |
| | T. J. Aylward, Milwaukee | a | a | a |
| | D. M. Willson, Milwaukee* | x | x | x |
| | John M. Beffel, Wauwatosa | x | x | x |
| | E. A. Habeck, Milwaukee* | a | a | a |
| | S. A. Morton, Milwaukee | x | x | x |
| | Richard Foregger, Milwaukee* | a | a | a |
| Monroe | S. D. Beebe, Sparta | a | a | a |
| | Harry Mannis, Sparta* | a | a | a |
| | D. C. Beeba, Sparta* | x | x | x |
| Oconto | H. A. Aageson, Oconto | x | x | x |
| | D. M. Bailey, Gillett* | a | a | a |
| Oneida–Vilas | Marvin Wright, Rhinelander | x | x | x |
| | I. E. Schiek, Sr., Rhinelander* | a | a | a |
| Outagamie | G. W. Carlson, Appleton | x | x | x |
| | H. T. Gross, Appleton* | x | x | x |
| Pierce–St. Croix | P. H. Gutzler, River Falls | x | x | x |
| | O. H. Epley, New Richmond* | a | a | a |
| Polk | L. O. Simenstad, Osceola | x | x | x |
| | V. C. Kremser, Amery* | a | a | a |
| Portage | A. G. Dunn, Stevens Point | x | a | a |
| | R. H. Slater, Stevens Point* | a | a | a |
| Price–Taylor | J. D. Leahy, Park Falls | x | x | x |
| | W. E. Niebauer, Phillips* | a | a | a |
| Racine | L. J. Kurten, Racine | a | a | a |
| | G. N. Gillett, Racine* | x | x | x |
| | L. E. Fazen, Jr., Racine | x | x | x |
| | R. J. Schacht, Racine* | a | a | a |
| Richland | D. J. Taft, Richland Center | x | a | a |
| | R. E. Housner, Richland Center* | a | a | a |
| Rock | R. A. Thayer, Beloit | x | x | x |
| | E. T. Rechlitz, Beloit* | a | a | a |
| | M. D. Davis, Milton | x | x | x |
| | R. W. Farnsworth, Janesville* | a | a | a |
| Rusk | L. M. Lundmark, Ladysmith | a | a | a |
| | Howard F. Pagel, Ladysmith* | x | x | x |
| Sauk | J. F. Moon, Baraboo | x | x | x |
| | J. J. Rouse, Reedsburg* | a | a | a |
| Shawano | F. W. Henke, Shawano | a | a | a |
| | D. A. Jeffries, Shawano* | a | a | a |
| Sheboygan | P. B. Mason, Sheboygan | a | a | a |
| | F. A. Nause, Sheboygan* | a | a | a |
| Trempealeau–Jackson–Buffalo | R. L. MacCornack, Sr., Whitehall | x | x | x |
| | F. C. Skemp, Fountain City* | a | a | a |
| Vernon | Frank Gollin, La Farge | a | a | a |
| | Edward Vig, Viroqua* | a | a | a |
| | R. S. Hirsch, Viroqua* | x | x | x |
| Walworth | E. D. Sorenson, Elkhorn | x | x | x |
| | E. D. Hudson, Lake Geneva* | a | a | a |
| Washington–Ozaukee | P. B. Blanchard, Cedarburg | x | x | x |
| | E. C. Quackenbush, Hartford* | a | a | x |
| Waukesha | M. J. Werra, Waukesha | x | x | x |
| | W. D. James, Oconomowoc* | x | x | x |
| Waupaca | M. A. Borchardt, New London | a | a | a |
| | W. G. Arnold, Clintonville* | a | a | a |
| Winnebago | R. H. Bitter, Oshkosh | x | x | x |
| | David Regan, Neenah* | a | a | a |
| | George Schwei, Menasha | x | x | x |
| | Warren V. Hahn, Oshkosh* | a | a | a |
| Wood | R. W. Mason, Marshfield | x | x | x |
| | W. L. Nelson, Wisconsin Rapids* | a | a | a |
| General Practice | G. E. Forkin, Menasha | a | a | a |
| | J. A. Grab, Sun Prairie* | x | a | a |
| | E. J. Schneller, Racine* | a | x | x |
| Internal Medicine | R. N. Allin, Madison | x | x | x |
| | R. A. Frisch, Milwaukee* | x | a | a |
| Neurology and Psychiatry | Harry Tabachnick, Milwaukee | x | x | a |
| | E. Madison Paine, Green Bay* | a | a | a |
| Obstetrics and Gynecology | A. A. Cantwell, Shawano | a | a | a |
| | W. O. Paulson, Eau Claire* | a | a | a |
| Ophthalmology and Otolaryngology | E. J. Zeiss, Appleton | x | x | x |
| | H. C. High, Jr., Milwaukee* | a | a | a |
| | A. H. Pember, Janesville* | x | x | x |
| Orthopedics | D. W. McCormick, Fond du Lac | a | x | a |
| | F. G. Gaenslen, Milwaukee* | x | x | x |
| Pathology | Gorton Ritchie, Milwaukee | x | x | x |
| | R. S. Haukohl, Milwaukee* | x | x | a |
| Pediatrics | F. J. Mellencamp, Milwaukee | a | x | a |
| | K. J. Winters, Wauwatosa* | a | a | a |
| Radiology | W. T. Clark, Janesville | x | x | x |
| | R. L. Troup, Green Bay* | a | a | a |
| Surgery | J. M. Sullivan, Milwaukee | x | x | x |
| | M. G. Rice, Stevens Point* | a | a | a |

*Alternate.

# Minutes of the Council Meeting, Land O'Lakes July 31 and August 1, 1954

**1. Call to Order**

The Council was called to order by Chairman Arveson at 9:45 a.m., Saturday, July 31, at Land O'Lakes.

**2. Roll Call**

Councilors present were Doctors Costello (Saturday evening and Sunday), Hill, Kasten, Dessloch, Heidner, McCarey, Bell, Garrison, Arveson, Ekblad, Galasinski, Casper, Wegmann, Zellmer, and Past-President Griffith.

Also present were President Tenney; Treasurer Weston; Speaker Simenstad; Vice-Speaker Fons; Dr. S. E. Gavin, delegate to the American Medical Association; Dr. M. J. Musser, chairman, Committee on Civil Defense; Dr. J. A. Enright, Committee on Public Policy; Dr. T. A. Leonard, chairman, Study Committee on Maternal Mortality (Sunday only); Dr. C. N. Neupert, state health officer; and Mr. R. R. Rosell, executive secretary, Minnesota State Medical Association.

Staff members and consultants present were C. H. Crownhart, secretary; Roy T. Ragatz and Earl R. Thayer, assistant secretaries; Robert B. Murphy, legal counsel; Carl A. Tiffany, actuary; Donald E. Gill, certified public accountant; and Misses Joan Pyre and Jean McGruer of the Society's office.

**3. New Business**

The chairman asked for new business to be added to the agenda. None was requested.

**4. Resolutions for Reference to the House of Delegates**

Physicians specializing in urology and physicians engaged in full-time public health activities requested the introduction of resolutions to recognize their specialties by the establishment of formal sections with delegate representation in the House of Delegates.

There was a long discussion of the subject, participated in by all councilors present, which covered the origin of the section representation and 1953 recommendations of the House on this subject. After the discussion, the following two actions were taken:

> On motion of Doctors Casper–Galasinski, carried, the Council directed that the two resolutions be forwarded to the House of Delegates without recommendation. (These resolutions are contained in the proceedings of the House, printed in another section of this issue of the *Journal*.)
>
> On motion of Doctors McCarey–Kasten, carried, the chairman of the Council was directed to appoint a committee of four to discuss the problem of a long-range study with the delegate representatives of the various sections now in existence.
>
> Chairman Arveson then appointed Doctors Griffith, Kasten, Casper, and Hill as members of the special committee.

**5. Report of the Committee on Public Policy re Chiropody**

At the February 1954 meeting of the Council, it was reported that a special study had been made, through the Committee on Public Policy, respecting amendment of the laws pertaining to chiropody. At that meeting the Council returned the subject to the committee for further study.

Dr. J. A. Enright, member of the Committee on Public Policy, presented a summary of the committee's recommendations, made after subsequent study; and Doctors Dessloch–Galasinski moved to approve the recommendation of the Committee on Public Policy. The motion was carried, for submission to the House of Delegates. Details of the report will be found in the printed proceedings of the House.

**6. Meeting with Blue Cross**

The Council had been advised previously that in June the Executive Committee of Associated Hospital Service, Inc. (Blue Cross of Wisconsin) had requested a joint meeting of the two groups, with the exclusion of all staff members, full-time or retained, at the earliest practical date and that an invitation had been issued to the Blue Cross Executive Committee to attend the July–August meeting. Subsequently, advice was received by Doctor Tenney that the Executive Committee would not be able to be present.

After discussion, it was moved by Doctors Bell–Casper that correspondence be directed to Blue Cross stating that the Council wished to meet with its entire Board and suggesting a date during the time of the Annual Meeting in Milwaukee, and that President Tenney be given full authority to make the necessary arrangements for such a meeting. This motion was carried by unanimous vote.

**7. Staff Reports**

Mr. Donald E. Gill, the Society's certified public accountant by Council appointment, spoke briefly on the financial affairs of the Society and said, "In connection with the accounting work of the Society, we are primarily in two fields. First, we act

as auditors, upon Council appointment, to see that the financial affairs of the Society are properly accounted for. In that field, we make any recommendations we feel are necessary. We also act in another field, when, upon request of the regular Society staff, we may act and give advice on general accounting matters."

Mr. Gill spoke of recommendations being made to foresee and insure proper accounting methods for the future as well as the present; said that more adequate quarters in the new building would be of value in providing more space for the development of liaison between the accounting and other departments; and stated finally that in his opinion, the financial affairs of the Society were being operated on a sound basis.

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Chairman Arveson then called on Mr. Carl Tiffany, the Society's actuary by Council appointment, to discuss the insurance program and phases of its current operations. Mr. Tiffany said "We do not have any problems to bring to your attention; but perhaps I can bring some assurances, from the viewpoint of the actuary, who has the responsibility for the rating structure of the premiums charged for the various contracts. In order to do that, we have to interest ourselves in the terminology and definitions that apply to the benefits and contract forms; we must interest ourselves very substantially in what we call "underwriting," that is, the selection and determination of the number of subscribers in a particular group and under what circumstances they will obtain coverage, in order that we may have some reasonable assurances that the assumptions made with respect to experience will be realized. And if there are any doubts in your minds, I think you certainly can be assured, not only from the historical picture that we get in accounting, but from our own judgment, that the insurance program is on a sound, adequate, stable basis."

Mr. Tiffany said he was satisfied with the operation of the experience, or merit rating, program and also the non-group program. As to the latter, he said that it had received careful study and that it is a sound program which will extend the area of usefulness of WPS throughout the state where group programs are not feasible.

The major medical illness expense program, said Mr. Tiffany, represents a distinct step forward, from both the actuarial and insurance company viewpoints. He said that the master contract for that coverage was, in his opinion, something of which Blue Shield in Wisconsin could be proud.

Finally, Mr. Tiffany discussed briefly the possibility of a form of Blue Shield deductible insurance and said that although there would be problems to be solved in that area, the idea is "in the right direction to make more efficient use of the premium or benefit dollar the public is paying for protection."

At this point, the Council recessed until Sunday morning, although it met informally Saturday evening to see the movie, "The Presence of Our Past," presented by Clifford L. Lord, director of the State Historical Society.

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**8. Committee on Civil Defense**

Dr. M. J. Musser, chairman of the Committee on Civil Defense, reported on its behalf and said that since the civil defense program has become an integral part of the state and Federal governments, the medical profession is faced with cooperation with civil defense authorities in order to assure adequate plans in case of disaster; and he emphasized that the stake of the medical profession is a tremendous one. Doctor Musser said that over the last four years the committee has worked closely with General Olson and Doctor Neupert in helping to perfect a plan for civilian defense, but that there are so many problems not yet solved, the members of the profession must "declare ourselves in a more positive manner" than has been done in the past.

Doctor Musser read the formal report of the committee and its recommendations (which are included in the transactions of the House of Delegates printed in another section of this issue of the *Journal*).

> The Council, on motion of Doctors Galasinski-Griffith, carried, approved the recommendations of the Committee on Civil Defense and on further motion of Doctors Hill-Kasten, requested Doctor Musser to present the report personally to the House of Delegates. The motion was carried unanimously.

**9. Report of the Maternal Mortality Study Committee**

Chairman Arveson called on Mr. Ragatz, assistant secretary, to discuss the background and history of the study on maternal mortality. Mr. Ragatz reported that at the outset, those connected with the development of the program felt two essential objectives should be sought. First, every effort should be made to emphasize that a study, and in no sense an "investigation," was being made; and it should have a scientific approach. Second, the mere gathering of statistics would accomplish little unless the study and committee could present some sort of follow-up program whereby the information and conclusions could be implemented into a purposeful course of instruction or interpretation for the medical profession.

Dr. T. A. Leonard, chairman of the study committee, discussed the work of the committee, and said, "It has been a serious and responsible business—serious because it deals with the tragedy of death, and responsible because it concerns the activities of physicians, hospitals, and families alike."

The formal report of the study committee was read by Doctor Leonard and discussed in detail, after which it was moved by Doctors Galasinski-

Casper, unanimously carried, that the committee be commended for a job exceptionally well done.

It was further moved by Doctors Hill–McCarey, that in final form the report be accepted and transmitted to the House of Delegates by Doctor Leonard personally at the time of its meeting in October. This motion was put to a vote and carried.

**10. SMS Charitable and Scientific Foundation**

At the May 1954 meeting of the Council, the staff was authorized to develop the details and machinery for an SMS Foundation, to be used for scientific and research activities, and to report its recommendations to the Council at the July meeting.

The statement and recommendations were presented to the Council for approval; and in a discussion of them, Mr. Murphy, legal counsel, pointed out that as the interests of the medical profession have expanded, it has become apparent that it might be desirable to consolidate some long-range projects into one category.

It was moved by Doctors Bell–Ekblad, carried, that the report be forwarded to the House of Delegates with recommendation for approval. (The complete proposal is included in the transactions of the House printed in another section of this *Journal.*)

**11. 1955 Summer Council Meeting**

Land O'Lakes was selected as the place for the 1955 summer Council meeting, on motion of Doctors Ekblad–Zellmer, unanimously carried.

**12. Adjournment**

There being no further business, the meeting of the Council adjourned at 12:30 p.m., August 1, 1954.

C. H. Crownhart
*Secretary*

**Approved:**
R. G. Arveson, M. D.
*Chairman of the Council*

# Minutes of the Council Meeting, Milwaukee October 3, 1954

**1. Call to Order**

The Council was called to order by Chairman Arveson at 10:30 a. m., Sunday, October 3, at the Schroeder Hotel, Milwaukee.

**2. Roll Call**

Councilors present were Doctors Costello, Hemmingsen, Hill, Kasten, Dessloch, Heidner, McCarey, Bell, Garrison, Arveson, Ekblad, Galasinski, Bernhart, Casper, Wegmann, Zellmer, Past-President Griffith, and Chairman Emeritus Gavin.

Also present were President Tenney; Treasurer Weston; Vice-Speaker Fons; Doctors Stovall and Witte, AMA delegates; Dr. C. N. Neupert, state health officer; Dr. R. M. Moore, Commission on Prepaid Plans; Dr. S. A. Morton, chairman of the House of Delegates Reference Committee on Reports of Officers; Dr. J. S. Devitt and Dr. C. G. Reznichek, advisors to Wisconsin chapters, Student AMA (Sunday evening only); Dr. R. C. Parkin, medical advisor; Mr. Frank W. Kuehl, legal advisor, Washington office of the AMA; and Mr. R. R. Rosell, executive secretary, Minnesota State Medical Association.

Staff members present were C. H. Crownhart, secretary; R. T. Ragatz and E. R. Thayer, assistant secretaries; T. J. Doran, claims director; Mr. Carl A. Tiffany and Mr. W. C. White, Jr., actuaries; Mr. Donald E. Gill and Mr. John B. White, accountants; Mr. Robert B. Murphy, legal advisor; and Misses Joan Pyre and Jean McGruer of the Society's office.

**3. Report of the Treasurer**

The report of the treasurer was presented by Dr. F. L. Weston, Madison, and approved for submission to the House of Delegates. The report is printed in its entirety in the House proceedings in another section of this issue of the *Journal.*

**4. Report of Audit and Budget Committee**

The minutes of the July 31, 1954, meeting of the Audit and Budget Committee were submitted as follows:

Committee members present were Drs. Dessloch, chairman; Bell; McCarey; and Wegmann. Also present were Doctor Tenney, president, and Doctor Weston, treasurer. Committee member absent, Doctor Fox. Staff members present were Messrs. Crownhart and Ragatz and Miss McGruer. Consultants present were Mr. Murphy, attorney, and Mr. Gill, independent certified public accountant.

(1) Retirement Plan

Mr. Murphy reported that his office had conferred and corresponded with United States Treasury Department officials in Milwaukee relative to the Employees' Retirement Plan & Trust Agreement which had been submitted by the Society several months ago. The office charged with analyzing and approving proposed plans of this character had found it satisfactory and was ready to rule it exempt, except for provisions relating to:

(a) The elements making up compensation which is to be the basis for retirement contributions. The Treasury Department

did not want bonus or additional compensation in any form included in such base in the case of any employee.

(b) Added contributions to the fund in the sole discretion of the Society, which contributions were to be credited to the account of a specified employee or employees. The Treasury Department felt this provision violated the provisions of the Internal Revenue Code, which requires that benefits or contributions be definitely determinable.

(c) Allowing an employee in any particular year to elect to contribute between 2 per cent and 4 per cent of his previous year's compensation from the Society, such contribution to be matched by the Society in addition to the 6 per cent fixed contribution. The Treasury Department requested that the contributory percentage of the employee be fixed in the agreement and that no fluctuation be allowed from year to year, except by amendment, on the basis that the fluctuating provision might tend to discriminate against the lower-salaried employees.

(d) Total compensation to employees, in whatever form, including bonuses, as the basis of the Society's contribution. The Treasury Department asked clarification of Section VI of the agreement in this respect so as to make the agreement consistent with the Treasury Department's request summarized in subparagraph (a) above.

Mr. Murphy was questioned on the above points by various members of the committee and was then asked for his recommendations. He recommended that the Society accept the four requests made by United States Treasury Department officials as above summarized but further recommended that efforts first be made to get a reversal of points (a), (c), and (d) above.

On motion of Doctors Bell–McCarey, carried, the committee unanimously authorized amendment of the retirement plan as submitted, with the four changes requested by United States Treasury Department representatives, and authorized the Society attorneys to endeavor to negotiate for a reversal of the three points specified above but further directed that no appeal be taken if such negotiations were unsuccessful.

(2) Petty Cash Account Increase

The secretary reported that the petty cash bank account was limited to $300 by action of some years ago. Checks are drawn on this account in relatively small amounts, and then an accounting is made to the treasurer as a reimbursement check is drafted on general funds. The secretary reported that with considerable increase in traveling and other activities of the Society, the amount in the account was too limited to be practical.

On motion of Doctors McCarey–Bell, carried, the maximum in this account was increased from $300 to $1,000.

(3) Salary Adjustments

Discussion was given to the status of employees of the Society, and the secretary was authorized to provide an adjustment by way of a one-time grant, without disturbing the basic salary structure of these employees. This action was taken on motion of Doctors Bell–McCarey, carried.

(4) Purchase of Golf Trophy

Mr. Ragatz explained that it seemed desirable that the Society provide a traveling trophy for low gross score in connection with the golf tournament held at the time of the Annual Meeting.

On motion of Doctors Bell–McCarey, carried, the staff was authorized to make such purchase at an expense not to exceed $150.

(5) Term of Office, Committee Members

The secretary reported that on action by the Council at its February 1954 meeting, the terms of members of the Audit and Budget Committee were established at two years. At his suggestion it was agreed that the terms would be assigned one year to the first two names in the alphabet and three years to the last three names in the alphabet.

(6) Group Life Insurance for Employees

Mr. Crownhart reported that the Blue Cross Commission, in conjunction with a national insurance company, had developed a group life insurance plan for employees of Blue Cross and Blue Shield. He thought that the availability of this insurance would very possibly extend to all employees of the State Medical Society in as much as functions in connection with Blue Shield are carried on by practically every individual in the office. The secretary was authorized to develop full details and to report the program to the Audit and Budget Committee in October 1954.

(7) Salary of the Secretary

There stands to the credit of the secretary an amount of money voted by the Council two years ago, and directed for deposit in the retirement fund. If such deposit cannot be made in accordance with Bureau of Internal Revenue Regulations, then the secretary was authorized to withdraw that sum.

(8) Appropriation to Division on School Health

The assistant secretary explained that two more school health conferences have been scheduled, probably to be held at Stevens Point and Milwaukee, but that authorization to expend up to $500 through other budgetary adjustments was necessary. Since this does not involve an increase in the budget as a whole, the Audit and Budget Committee approved it on motion of Doctors McCarey–Bell, carried.

The committee adjourned after taking the above actions.

On motion of Doctors Dessloch–Garrison, carried, the Council acted to approve the report of the Audit and Budget Committee.

5. Iowa Indoctrination Program

President Tenney reported on his attendance at an indoctrination program sponsored by the Iowa State Medical Society. It was described as a one-day institute for new members, to discuss and acquaint them with the various activities of the society. Doctor Tenney said the event was extremely worth while but that if such a program were to be attempted in Wisconsin, it might better be scheduled in connection with another affair, such as the Annual Meeting, in order to insure good attendance.

After some discussion it was moved by Doctors Tenney–Ekblad that steps be taken to implement the idea of integrating such a program with the Annual Meeting of the State Medical Society of Wisconsin, with emphasis in the program placed on some of the neglected phases of medical economics. The motion was put to a vote and carried unanimously.

6. Management Services

At the November 1953 Council meeting, on prior instruction, a special staff report was submitted, discussing the development in recent years of various types of management organizations created primarily to serve professional offices. It was pointed out that the services included in such organizations are accounting, budgeting, collection advice on outstanding accounts, and periodic check of office procedures. It was further stated at that time that, in the opinion of the staff, these organizations have a place and there is a need for them.

The subject had been under study for some time, and as a result the staff recommended that it be authorized to develop a series of standards under which an organization may secure approval of the State Medical Society for advertising in *The Wisconsin Medical Journal*, exhibiting at the Annual Meeting, and representing itself as approved. Approval could be obtained, however, without any requirement that such an organization either advertise or exhibit. In light of such authorization, given at the November 1953 meeting, the following "standards" were submitted for Council approval:

Standards for Management Services Desiring to Advertise in *The Wisconsin Medical Journal*

1. Advertisements and all official letterheads and publications of such organization shall list the proprietors thereof if the service utilizes a trade name.

2. Any changes in proprietorship shall be reported at once by registered mail to the State Medical Society.

3. No individual associated with such service shall provide services usually and customarily provided by attorneys at law, unless such individual is an attorney at law and the services provided by him are in manner approved by the Wisconsin Bar Association.

Such services shall be deemed to include rendering advice upon the content and meaning of statutes and official regulations of any governmental agency, or the intent or legal effect of any contractual agreement proposed or entered into by clients of such service.

4. No individual associated with such service shall provide services usually and customarily provided, in their practice as public accountants as defined by Section 135.02 of the Wisconsin Statutes, by certified public accountants or public accountants, unless such individual is a duly licensed certified public accountant or a duly licensed public accountant and the services provided by him are in a manner consistent with the Code of Ethics prescribed by the Wisconsin State Board of Accountancy.

5. No person associated with such service shall receive compensation for services rendered customers thereof except from such customers.

6. No such service shall advise its customers directly or indirectly that any character of privilege or confidential communication exists as between the service and the customer.

7. No such service shall advertise or promote its services as "professional" unless personnel available to render those services is an attorney or a certified public accountant or duly licensed public accountant, in which case the identification of the individual and the extent to which the services are professional in character is clearly stated.

No such service shall advertise the services of an attorney, a certified public accountant, or a duly licensed public accountant in any manner contrary to the Code of Ethics of the Wisconsin Bar Association or of the Wisconsin Society of Certified Public Accountants or of the Wisconsin State Board of Accountancy, respectively.

8. No such service shall enter into any business arrangement with its customers in which any individual of the service becomes an employee of the customer. The status of independent contractor must be clearly defined and maintained.

9. No such service shall act as a collection agent for its customers unless licensed by the State of Wisconsin and the fact of the licensure reported annually to the State Medical Society.

10. No person associated with such service shall investigate or cause to be investigated through any other independent agency customers served by it except for the purpose of securing a financial rating.

On motion of Doctors Kasten–Ekblad, carried, the Council approved the standards as submitted, although Dr. E. M. Dessloch, Prairie du Chien, asked to be recorded as voting "no."

7. Schedule of Meetings

A tentative schedule of meetings of various committees and events was submitted; and on motion of Doctors Dessloch–Heidner, the following Council meeting dates were approved:

February 26, 27, 1955
April 30, May 1, 1955
July 29, 30, 1955

8. Report of the Interim Committee, July

At the July–August meeting the Interim Committee took the following actions which could not be considered by the Council prior to its adjournment:

(a) State-wide Organization of Medical Assistants

In several areas of the state office employees of physicians have been formally organized and hold periodic meetings. There is a successful organization in Milwaukee County, with its affairs being reported in the *Milwaukee Medical Times*. There are state-wide organizations in Michigan, Kansas, Oklahoma, and Missouri.

The purpose of these organizations is not to protect the economic status of office employees but to provide for the exchange of ideas and other information that will make each employee better informed and more capable.

The Interim Committee, on motion of Doctors Galasinski–McCarey, carried, recommends that the Council approve a state-wide organization, providing that it is at no cost of time or money to the State Medical Society.

It was moved by Doctors Kasten–Garrison that the recommendation be approved. The motion was put to a vote and carried. Dr. V. E. Ekblad, Superior, asked to be recorded as voting "no."

(b) Award to Physician for Contribution to Employment of Physically Handicapped.

The American Congress of Physical Medicine and Rehabilitation, composed of a number of related organizations, annually cites a physician outstanding in the field of the care and rehabilitation of the physically handicapped. On several earlier occasions the Wisconsin committee has asked the State Medical Society for nominees who might be considered for such citation.

It is the recommendation of the Interim Committee that this entire matter be referred to the Commission on State Departments and its Division on Rehabilitation and that the Commission be empowered to submit nominations if it so desires.

Doctors Dessloch–Bell moved that the recommendation be approved and the matter referred to the Commission on State Departments. The motion carried.

(c) Variation in Benefits to Participating and Non-Participating Physicians—Major Illness Expense Program

A physician's letter of protest was directed to the Council in connection with the proposed payments to participating and non-participating physicians under the major illness expense program, as described in the June "Forum" section of *The Wisconsin Medical Journal*. The Council's attention was directed to a statement prepared by the Executive Committee of the Commission on Prepaid Plans in explanation of this situation, which statement was forwarded to the physician; and on Interim Committee recommendation, Council approval was given to staff handling of the matter. The statement follows:

*(Excerpt from records of the Executive Committee of the Commission on Prepaid Plans, June 27, 1954)*

The Executive Committee of the Commission on Prepaid Plans recognizes that the development of Major Illness Expense Insurance will bring about many problems, some of which can be foreseen and others of which will appear as installation of the program becomes more extensive.

The committee is in no doubt whatsoever that the program as it exists initially will be subjected to repeated changes until it has passed through a "try-out" period. The State Medical Society has had the same experience with the basic coverage offered under the identity of Blue Shield.

One of the major problems with which the new plan is confronted arises out of the fact that benefits cannot be scheduled as is the case with the base program. That is, the claims arising out of major illness expenses will seldom involve appendectomies, tonsillectomies, or similar conditions, all of which can be "scheduled" for a particular benefit under the base program.

Therefore, the major illness program contains no scheduling of benefits and simply makes the provision that its benefits will be based upon the customary and reasonable charges encountered. Similar programs of other organizations, so far as the committee is aware, do not recognize such charges as entitling the policyholder to 100 per cent reimbursement. A quite general provision is that the insuring organization will pay 80 per cent of such reasonable charges, thus placing the policyholder in a position of being partly responsible for his bills and being interested, financially, in the management of his costs.

Another factor enters the actuarial picture at this point. Blue Shield of Wisconsin, in providing benefits in its basic program, generally for acute conditions, is dealing for the most part with physicians in Wisconsin or in communities bordering upon this state. However, in providing benefits in the field of major illness expenses it is recognized that many situations will arise in which benefits are being paid in other areas. The policyholder who suffers from a coronary may obtain medical care elsewhere as he decides to recuperate, for example, in the South dur-

ing Wisconsin's winter months. His physician may recommend treatment elsewhere, or the patient himself may choose some other area for medical consultation.

This experience will have a direct bearing upon the rates which are charged for the Major Illness Expense Policy. Blue Shield of Wisconsin is but a state-wide organization. It cannot follow the pattern of some other organizations which specifically "rate" areas of the country based upon experience in each.

In developing the Major Illness Expense Policy it was determined to provide reimbursement to the policyholder in the amount of 100 per cent of the charges of those physicians who participate in the basic program of Blue Shield. This is encouragement to the beneficiary to stay within the confines of his state, for it is the circumstances of Wisconsin upon which the entire program is based. If the patient seeks attention elsewhere, the plan will pay 80 per cent of reasonable and customary charges.

Question is raised concerning the non-participating physician in Wisconsin. It is said that the plan discriminates against him. It is a natural reaction for one in his position. But why is he not participatin? It is because he does not now subscribe to the full payment provisions inherent to the ultimate success of Blue Shield. Thus, he may well make charges in excess of the basic program which will bring the professional services involved into the major illness expenses field, while the participating physician in the same situation would charge, and receive, the scheduled benefit.

Obviously, then, if the program fully recognized his charges, it would be discriminating in his favor and against the participating physician whose charges in many cases, because of the full payment provisions of the base program, would be within its total benefits even though the major illness program did not exist.

It must be recognized also that the participating physician does more than simply subscribe to the full payment concept of the basic Blue Shield program. He commits himself to that principle on a continuing basis. He can withdraw but annually. He guarantees the plan's benefit, thus eliminating the necessity of providing for losses through expenditure of capital obtained from outside sources. It is the participating physician who provides the "service concept" of Blue Shield.

In time, and with experience, it is hoped that the purchaser of the major illness expenses program may have the option of buying, at additional cost to himself, 100 per cent protection in the event he seeks services from a non-participating physician, whether that physician is or is not a resident of Wisconsin. At this stage of development, however, that cannot be done.

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At this point, 12:25 p.m., the Council recessed for luncheon and a meeting which was scheduled with the Executive Committee of Associated Hospital Service, Inc. (Blue Cross). At the latter's request, the staff and consultants were not present. The regular Council meeting reconvened at 7:50 that evening.

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**9. Report of Interim Committee, October**

(a) Resolutions to the House of Delegates

Three resolutions offered by the Interim Committee had to do with commendation of the Governor's Conference on Highway Safety, endorsement of National Nurse Week, and support of the Auxiliary's campaign to increase subscriptions to *Today's Health*. It was the committee's recommendation that if the Council approved the resolutions, they could be acted upon in a single motion for referral to the House. Approval was then given to the resolutions on motion of Doctors Kasten–Bell, carried. These resolutions will be found in the proceedings of the House in another section of this issue of the *Journal*.

(b) Provident Group Program

The experience with the Provident group program demonstrates that it is of great value to the participating physician but that due to the widely scattered location of new members, enrollment is rapidly dropping below the minimum required to maintain the program.

The Interim Committee recommends that initial enrollment of new members of the Society be undertaken by the staff and that arrangements be worked out with the Provident Insurance Company and Marsh & McLennan, brokers, so that the Society is reimbursed its direct and indirect expense in connection with this program.

On motion of Doctors Heidner–Hemmingsen, carried, the Council acted to approve this recommendation.

(c) Future Annual Meetings

In order to partially solve the problem of "too many medical meetings," to give those having interests in specialties opportunity for special programs, and to strengthen attendance at the Annual Meeting, it has been recommended by the Council on Scientific Work and approved by the Interim Committee that plans be made to devote a morning session to a series of presentations in selected fields at future annual meetings.

It was moved by Doctors Ekblad–Hill, carried, to approve the proposal for referral to the House of Delegates.

(d) In connection with a vacancy on the Interim and the Audit and Budget committees, it was moved by Doctors McCarey–Bernhart, unanimously carried, that Dr. H. Kent Tenney be appointed.

**10. Student American Medical Association**

At the November 1953 meeting of the Council, action was taken to invite the advisors to the two Wisconsin chapters of the SAMA to report on activities for the year.

Dr. J. S. Devitt, Milwaukee, advisor to the Marquette Chapter, submitted the following report:

"Members of the Council and guests: I am very happy for the opportunity to present this report on the development, progress, and activities of the Marquette Chapter of the Student American Medical Association. The chapter is a very active and enthusiastic one and boasts an enrollment of almost 100 per cent of the entire student body.

"I would like to outline briefly some of the recent activities of the SAMA at Marquette. One very interesting project has been the development of an internship questionnaire, the purpose of which is to provide a reference source on hospital internships for present and future medical students. The details of the questionnaire are well conceived and represent a careful attempt to evaluate internships soundly and objectively.

"Another undertaking of the Marquette Chapter has been the sponsorship of a Career Guidance Day, through which an opportunity is afforded high school and college students to obtain first-hand authentic information on medical education and medical practice. Featured on this program were a panel discussion on premedical education, a moving picture on medicine as a career, and group discussions with medical students. The chapter sponsors an orientation program for freshman medical students which has proven very helpful.

"Like our own organization, the chapter accomplishes most of its work through committees. It holds monthly meetings at which the business of the chapter is conducted and a program on some subject of medical interest, either scientific or otherwise, is presented. Some of the programs presented during the last year dealt with expert medical testimony, by a member of the faculty of the Marquette University Law School; the activities, duties, and responsibilities of medical officers under fire, by a member of the Army Engineers Corps; and panel discussions on general practice and the medical specialties by practicing physicians.

"A few social activities are directly sponsored by the chapter.

"I am proud to report that the chapter has exerted significant influence in the national organization, and some of its members have exhibited qualities of leadership that have been recognized by their election to offices in the national organization.

"The Marquette Chapter has been influential in the success of a group life insurance program, through which members may obtain up to $5,000 of term insurance at very low premiums. The insurance is convertible to permanent types of insurance within four years following graduation.

"This year the chapter will be represented by observer delegates at the meetings of the House of Delegates of this Society. The extension of this privilege by the State Medical Society affords them a good opportunity to observe organized medicine function. It serves the more subtle purpose of making these embryo doctors feel that they 'belong.'

"The members, through their officers, have indicated a desire to be able to gain admission to the exhibits and scientific sessions of the convention of the State Medical Society upon presentation of their SAMA membership cards. It is my understanding that such arrangements have been made.

"I would like, if I may, to supplement this factual report with two brief recommendations. The first is to urge this Society to continue its moral and material support of the two chapters of the SAMA in this state. The movement is a very healthy one, and the organization has exhibited by the statement of its objectives and by its performance as well that it is an asset to organized medicine. Not only is it a bulwark against the infiltration among our young doctors and medical students of some of the nefarious, subversive movements which were a serious source of concern and embarrassment to our profession not so many years back, but it will serve, I venture to predict, as an excellent incubator and training ground for our medical leaders of the future.

"My second recommendation is that we attempt to maintain closer liaison with this group, not at all with the idea of dominating them, but rather for the purpose of our better understanding them and their better understanding us. A number of methods by which this could be accomplished suggest themselves. It would seem desirable that chapter officers discuss chapter activities and plans at more frequent intervals—and, again, I hasten to emphasize that the suggestion for such discussions stems from feelings of benevolent interest rather than from any desire to curtail independent, autonomous thought and action. On our part, a wider distribution of *The Wisconsin Medical Journal* to chapter officers and committee chairmen would serve to familiarize them with the problems and activities of organized medicine in this state. Observer representatives on certain committees and councils would possibly serve the same purpose. The State Medical Society could easily encourage scientific medical groups, specialist societies, the Academy of General Practice, and similar organizations to extend invitations to the members of the SAMA to attend their scientific programs.

"In closing, may I state that it has been a privilege not only to represent the State Medical Society of Wisconsin to the Marquette Chapter of the Student American Medical Association, but also to be associated with an organization which has exhibited such enthusiasm, sound thinking, wholesome leadership, and ability for accomplishment."

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Dr. C. G. Reznichek, Madison, advisor to the University of Wisconsin Chapter, submitted his report as follows:

"During the past two years, I have acted as advisor to the Student AMA at the University of Wisconsin.

"The Student AMA at the University of Wisconsin Medical School became organized somewhat over

a year ago. The initial organization came spontaneously from the medical students without any influence on my part, and an excellent organization spontaneously grew. During the past school year, 86 per cent of all students enrolled in medical school and 92 per cent of the students of the first three years of medical school were members of the Student AMA. The organization at the University of Wisconsin is a very active one. Most of the routine business and planning is done by the Council, which is made up of a representative of each class, plus the officers of the Student AMA and a representative of each medical fraternity and a member representing the medical sorority. This group, during the past year, met on the average of once every one to two weeks. The organization is governed by the constitution, which is appropriate and in good order.

"Advisors to the Student AMA include medical school advisors, Doctors Stovall and Youmans, and Dane County Society advisor, Doctor Gearhart.

"In the fall of 1953, the officers of the Student AMA met with Mr. Earl Thayer of the State Medical Society, Doctor Gearhart, and myself in a discussion of activities of the Student AMA and for an exchange of ideas from the standpoint of the advisors and the Medical Society.

"The Wisconsin group has had three meetings during the year at which speakers presented talks. The programs were as follows:

"At the first meeting, Dr. John Harris talked on female idiosyncrasies.

"The second meeting was a panel discussion, the panel being Doctor Kindschi of Monroe, Doctor Hinke of Richland Center, and Doctor Collins of Madison. The main subject discussed was general practice in cities and rural communities. There were 150 students in attendance, and it was considered a very highly successful and instructive meeting.

"The third full meeting had an internship panel for the program. An army intern, an intern at the Wisconsin General Hospital, and an intern from Madison General led the discussion of the pros and cons of the various types of internships.

"The organization publishes a newsletter, three issues having been published in the last year and distributed among the members to inform them of activities and items of interest. It is my impression that the newsletter has been very well done and well received.

"In checking with various faculty members of the Wisconsin Medical School, it is my impression that the Student AMA at the University of Wisconsin is well thought of and well received by the faculty. The Dane County Medical Society has shown a very active interest in the Student AMA and through its advisor, Doctor Gearhart, is attempting to be of assistance.

"Regarding the national meeting of the Student AMA, it is noteworthy to find that the University of Wisconsin Student AMA had the largest delegation of any school attending the meeting in Chicago; there were 90 members present. The Medichoir of the University of Wisconsin Medical School entertained at some time during the convention. Gene Weston, last year's president of the Wisconsin Chapter, acted as chairman of the Reference and Miscellaneous Business Committee and, at the present time, is an officer of the National Council of the Student AMA. The officers of the Wisconsin Chapter of the Student AMA are as follows: Wayne Munson, president; James Brandenberg, vice-president; John Simpson, treasurer; and Bernice Vandenburg, secretary.

"Plans for activities during the present school year are well under way. The newsletter is being distributed to all incoming freshmen. This copy contains things which will be of interest to and be helpful to freshmen during medical school. A get-acquainted party was planned for the freshman class and was to be attended by the students of the medical school and the faculty.

"This year, as was done on three occasions last year, noon hour movies on medical subjects will again be shown as a part of the program. These movies last year were very well attended, and much enthusiasm was shown.

"At some time during this coming school year, it is planned to have a friendly curriculum evaluation, probably on the forum-type basis, to exchange views between faculty and students.

"Conclusions: The Student AMA at the University of Wisconsin is well organized. The aims, ideas, and future plans of the organization are of the right type and worthy of our support."

The reports of Doctors Devitt and Reznichek were unanimously approved, on motion of Doctors Ekblad–Costello, with the request that, if possible, the advisors also present their reports to the House.

**11. Report on the Student Loan Fund**

The annual report on the Student Loan Fund for the period July 1, 1953, to June 30, 1954, was submitted on behalf of the Board of Trustees and reviewed by the Council. It was approved, on motion of Doctors Kasten–McCarey, carried, with the recommendation that it be referred to the House of Delegates. Further details will be found in the House transactions, printed in another section of this issue of the *Journal*.

**12. Special Report of the Commission on Prepaid Plans**

In addition to the regular report of the Commission, which was printed in the *Handbook for Delegates*, there was a supplementary report, which was presented by President Tenney on behalf of the Commission. This report included details of future planning and recommendations. Doctors Ekblad-Kasten moved to approve the report, with the rec-

ommendation that it be read to the House of Delegates by President Tenney and, further, that the secretary be requested to supplement the report with a statement to the House concerning Blue Shield-Blue Cross and the national picture. The motion was carried unanimously, and details of both the report and the secretary's statement are included in the printed transactions of the House.

13. **Adjournment**

The October 3, 1954, meeting of the Council adjourned at 10:45 p.m.

C. H. Crownhart,
*Secretary*

Approved:
R. G. Arveson, M. D.
*Chairman of the Council*

# Minutes of the Council Meeting, Milwaukee October 6, 1954

A special meeting of the Council was called to order by Chairman Arveson at 2:55 p.m., October 6, 1954, at the Milwaukee Athletic Club, Milwaukee.

Councilors present were Doctors Hill, Kasten, Heidner, McCarey, Garrison, Arveson, Ekblad, Galasinski, Bernhart, Casper, Wegmann, Zellmer, and Past-President Griffith. Also present were President Tenney; Speaker Simenstad; Vice-Speaker Fons; Doctors Witte and Stovall, delegates to the American Medical Association; Dr. Robert Moore; Dr. T. W. Tormey, Jr.; Dr. Justus Ohage, president, Minnesota State Medical Association; Dr. W. H. Howard, president, Indiana State Medical Association; and Dr. R. C. Parkin, medical advisor.

Staff members present were C. H. Crownhart, secretary; T. J. Doran, claims director; E. R. Thayer, assistant secretary; Robert B. Murphy, legal counsel; Carl A. Tiffany and W. C. White, Jr., the Society's actuaries; Donald E. Gill, independent certified public accountant; Paul R. Doege, sales coordinator; and Misses Joan Pyre and Jean McGruer of the Society's office.

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Chairman Arveson called on the secretary to state the problem before the meeting.

The secretary referred to the statement made before the House of Delegates on Monday, October 4, in which he discussed the problem of enrollment of Federal employees nationwide in Blue Shield. He pointed out that in accordance with action of the House, in which it expressed confidence in the discretion and judgment of the Council and Commission on Prepaid Plans to handle these matters as they arise, instructions were requested from the Council as to the part, if any, Wisconsin should play in the special conference of Blue Shield plans scheduled in Chicago, October 11, 1954. The secretary said further that the staff wished specific instructions as to its representation of the medical profession in Wisconsin at the special meeting and recommended the adoption of a statement of policy.

After a long and detailed discussion, and on motion of Doctors McCarey–Ekblad, carried, the following statement was adopted:

"Wisconsin Physicians Service, also known as Blue Shield of Wisconsin, a prepaid health care plan, is operated wholly within the corporate structure of the State Medical Society of Wisconsin.

"The Council of the State Medical Society is the executive body of the House of Delegates between its sessions and serves as the board of trustees of the Society.

"The Council has delegated to its Commission on Prepaid Plans the operation of Wisconsin Physicians Service, which is a member of a national trade association known as Blue Shield Medical Care Plans.

"Information has recently been received which, although most incomplete as of this date, appears to establish that a committee representing Blue Shield Medical Care Plans has been negotiating, apparently for a long time, with the United States Civil Service Commission in the development of specifications for basic surgical-medical coverage, plus major illness coverage, for all federal employees throughout the United States.

"These negotiations appear to be developing specifications in such manner as to commit the entire insurance program of medical and surgical benefits to Blue Shield plans through a form of centralized administration, providing these plans conform to the specifications.

"Such proposed specifications provide that the U. S. Civil Service Commission 'establish by regulation the policy, procedures and requirements of the program,' and further provide that in the field of major medical expense illness the Department of Health, Education, and Welfare would in the course of the development of the details of the policy 'list those conditions which it thinks may result in prolonged illness.'

"In the material made available to the Council it does not appear that the medical profession has either been informed or its advice sought with reference to these negotiations. Those who are negotiating apparently were authorized to do so by the executive committee of the Commission directing the affairs of Blue Shield Medical Care Plans, Inc. These negotiators seem to be acting as salesmen, but in that effort it would appear that they are actually concerning themselves with policy matters which should have prior consideration before being offered.

"On the basis of the information thus far available, it appears that all these negotiations may lead to the drafting of legislation which if enacted by Congress would give the necessary authorization for the ultimate purchase of the program. It is important to note in this respect that despite the form of the legislation at the time it is introduced, there is no assurance that some other points would not be added by way of amendment, such as a uniform schedule of benefits and supervisory control within federal authorities.

"At least three dangers attend these negotiations, and include: first, the invasion of the autonomy of Wisconsin Physicians Service through the negotiations conducted in its trade name by representatives of Blue Shield Medical Care Plans, which cannot commit Blue Shield of Wisconsin to matters of legislative policy; second, the commitment of Wisconsin Physicians Service to a uniform program of national coverage of some two and a quarter million federal employees without affording a fair and reasonable opportunity to consider the problem and its relation to the general public and the medical profession; and third, establishment by statute and government regulation of a fixed pattern of surgical, medical and major illness benefits on a uniform basis applicable throughout the United States, which pattern may or may not be in the best health interests of such federal employees or of other segments of the public, or fair to local plans and the millions now insured by them.

"The Council believes that federal employees residing within Wisconsin should have the advantage of any other citizens of Wisconsin and be able to secure the kind of prepaid insurance that is known as Blue Shield of Wisconsin. Federal employees should not be discriminated against, nor should there be discrimination in their favor.

"Local option as to choice of plan by individuals and local autonomy of individual plans are principles so fundamental that they must be specially emphasized.

"The Council suggests that the Commission, by inquiry to plans, insurance officials, medical societies, the Congressional delegation of Wisconsin, and others, endeavor to obtain answers to the following questions:

1. Has Blue Shield Medical Care Plans, Inc. made any general policy and legislative commitments in these or other negotiations with the U. S. Civil Service Commission?

2. Does the U. S. Civil Service Commission have authority to engage in preliminary negotiations which apparently would develop legislation limiting its future statutory authority to the installation of only one type of surgical-medical protection for federal employees? In other words, is it proper administrative power to deny free choice of insurance plans to federal employees?

3. Article II of the Constitution of Blue Shield Medical Care Plans, Inc. states that inherent in its objectives is 'a recognition that state and local medical care plans should be autonomous in their operation, so that the needs, facilities, resources and practices of their respective areas can be given due consideration.' The Council inquires as to whether this principle is being destroyed in these reported negotiations.

4. What allowances, if any, have been made for local contract variations which are based on the medical care needs of the local areas?

5. Are there implications in these negotiations which should be considered by the state insurance commissioners?

6. Are the membership standards contemplated or imposed in connection with affiliation of local plans for the purpose of using a national symbol of such character as to involve the plans in situations which may be contrary to public policy? The Council believes that the Commission should instruct legal counsel to immediately examine that situation.

7. The Council understands that the American Medical Association has named two members of the Commission of Blue Shield Medical Care Plans, Inc. In the spring of 1955 it will name a third. The Council believes that the Commission should inquire of these physicians relative to their duties and responsibilities as Commissioners representing the AMA and whether any recommendations have been made by them with reference to these negotiations.

8. The Council understands that the Commission which is the board of directors of Blue Shield Medical Care Plans, Inc. is composed of lay executives as well as physicians in the practice of medicine. Should the policy making board have any individual serving upon it who is in any executive capacity with an individual Blue Shield plan?

9. In Wisconsin the medical profession supports the full payment principle and in negotiating on a national basis it would seem that the policy determinations of each state should be respected."

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An item from the Interim Committee report, which was not taken up at the regular Council meeting, was directed to the attention of Councilors:

> Because of the pressure of other work, Dr. J. A. Schindler has resigned as a member of the Commission on State Departments and particularly as chairman of the Division on Geriatrics.
>
> The Interim Committee suggests Dr. A. M. Hutter, of Fond du Lac, to fill the vacancy but is aware of the fact, of course, that nominations are made from the floor.
>
> On motion of Doctors Zellmer–Hill, carried, Doctor Hutter was appointed to fill the vacancy.

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There being no further business, the special meeting of the Council adjourned at 4:40 p.m., October 6, 1954.

C. H. Crownhart,
*Secretary*

Approved:
R. G. Arveson, M. D.,
*Chairman of the Council*

# THE WISCONSIN MEDICAL JOURNAL

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# « « « EDITORIAL » » »

## More Doctors for America

Critics of the medical profession who have been wildly claiming an alleged shortage of doctors and a scarcity of teaching facilities will find no comfort in the latest annual report on medical education in the United States.

That report, by the American Medical Association, tells a heartening story of continued progress and expansion to produce an ever-increasing supply of well-trained physicians dedicated to the welfare of their patients. Among the highlights:

—The number of doctors is at a record low ratio of one for every 730 persons, a proportion exceeded only by Israel, which has an abnormal number of refugee physicians.

—The nation's medical schools have record total enrollments and graduating classes and the largest freshman class.

—Ten new four-year medical schools are scheduled to begin operation within the next five to six years and three more are under consideration.

The expansion bears out the opinion of many medical education experts that the big problem in the near future may be a shortage of well-qualified applicants rather than a shortage of teaching facilities.

Young people will be interested that only 21 per cent of the freshmen entering medical school last fall had "A" averages in their premedical studies, 69 per cent had "B" averages, and 10 per cent had "C" averages.

In other words, they don't have to be "grinds," bookworms, or Phi Beta Kappas to get into medical school. Most young people who have the character and a sincere desire to serve their fellow men as physicians have an excellent chance of entering medical school.

Medical school enrollments have steadily increased over the past 20 years as existing schools have augmented their faculties and facilities and new schools have developed. The American public, the medical profession, and the medical schools have every right to take genuine pride in the tremendous advances that have been made in medical education. The American public, especially, should be deeply conscious of the high quality of medical care to which it is privileged.

*Facts about*

THE DOCTORS PLAN

THE BLUE SHIELD PLAN
OF THE
STATE MEDICAL SOCIETY OF WISC

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON PREPAID PLANS

## Blue Shield Is "The Doctors' Plan"

August 18, 1954.

Mr. Robert D. Potter, Editor,*
New York Medicine,
Medical Society of the County of New York.
Dear Mr. Potter:

I have just read the editorial in the August 20th issue of New York Medicine entitled "Where Goes Blue Shield?"

In this editorial you quote me as having said: "No plan can be successful without the cooperation of the doctors who deliver the services." Not only did I say this but I would like to reiterate it. Also, I should like to state that I agree fully with the whole content of the editorial.

Blue Shield is "The Doctors' Plan." The doctors must take an interest in it and guide it in its program. While, theoretically, UMS is an insurance company, practically, it is not. The reason is that an insurance company is guided by consideration of dollars and cents only. UMS must consider the reactions and ideas of the medical profession as well as the actuarial factors.

We have to face reality and it is becoming increasingly apparent that if we are to fulfill our objective we must expand our coverage, particularly in the non-surgical field, and must also raise our service benefit ceiling. In order to meet the demands of unions and the general public, the service benefit ceiling must cover more than half of the population. Our present ceiling of $4,000 family income ceiling only covers about one-third of the population. Any increase in the ceiling must, likewise, be accompanied by an increase in payments to the physician. To do this the premium must be raised. Yet, it cannot be raised to the point where no one will pay for the coverage.

There are many problems and UMS needs not only the cooperation of the doctors in carrying out the plans but their advice on how to proceed with new plans. No Blue Shield corporation can be allowed to proceed on its own and disregard the profession. It was started by the doctors and the doctors must supervise it. So long as I am Chairman of the Board of UMS I assure the profession that it will be consulted at the planning level.

When we ask for opinions and advice I hope that we shall get both promptly. Only in this way can we have harmonious and progressive leadership in the health protection of the public.

Sincerely yours,
LOUIS H. BAUER, M. D.
*Chairman of the Board*

*Reprint of a letter which appeared in *New York Medicine*, Vol. X, No. 18, September 1954, in response to an editorial reprinted here in November. Doctor Bauer, in addition to being chairman of the Board of United Medical Service, the Blue Shield Plan of the State Medical Society of New York, is a past-president of the American Medical Association.

For information or advice

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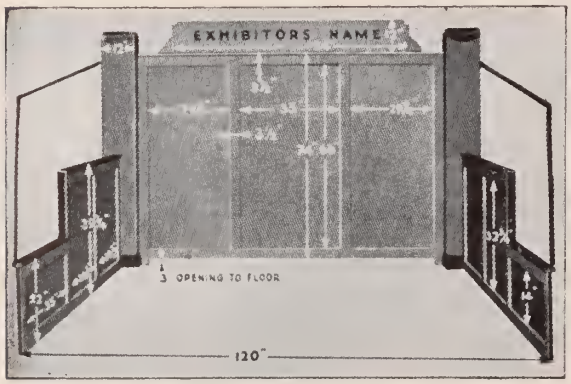
**1955 ANNUAL MEETING** **MILWAUKEE** **MAY 3–4–5**

★

THE Council on Scientific Work is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1955 Annual Meeting. The exhibits will be located in Bruce Hall of the Milwaukee Auditorium.

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space at the 1955 meeting are requested to file an application BEFORE FEBRUARY 1, giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed.

In-state exhibitors will have the following facilities provided by the State Medical Society: Wooden booth, electrical connection, shelving or tables, and identifying sign.




*The exhibitor must furnish:* Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, special lighting equipment, and half the cost of any drapes rented (rented through Badger Flag and Decorating Company at time exhibit is installed).

Booths for scientific exhibits are constructed of gray wood, in the dimensions shown on the chart at the left. Display space at back panel: 6′5″ high. Display space at sides: 6′5″ in height for 5′10″—remaining 3′2″ is 4′10″ in height.

Those interested in providing an exhibit are required to file an application and a full description of the exhibit by February 1. *No applications can be accepted after that date.* Address your communications to L. G. Kindschi, M.D., director of scientific exhibits, % The State Medical Society of Wisconsin, 704 East Gorham St., Box 1109, Madison 1, Wis.

# APPLICATION

## For Participation in the Scientific Exhibit

**1955 ANNUAL MEETING MILWAUKEE MAY 3-4-5**

## *Fill Out and Mail to:*

L. G. KINDSCHI, M. D., *Director of Scientific Exhibits*
c/o State Medical Society of Wisconsin
704 East Gorham Street
Box 1109
Madison 1, Wisconsin

1. Title of exhibit:_____

2. Description of exhibit (attach 200-word description to this blank):_____

3. The standard booth is 10′ wide and 9′ deep. What is the *minimum* space your display will require?_____
(Space is scarce so do not request more than is necessary).

4. Will radiologic viewing boxes be used? If so, will you furnish them?_____
(The State Medical Society does not have equipment of this character available).

5. Name of exhibitor:_____

6. Name of institution cooperating in exhibit: _____

### FILM ON CLEFT PALATE CHILD AVAILABLE

A new movie, "The Wisconsin Cleft Palate Story," in sound and color, has been produced by the Bureau for Handicapped Children, Department of Public Instruction, in cooperation with the University of Wisconsin Medical School, Department of Speech, and University Hospitals. It shows the integration of services necessary in the habilitation of a cleft palate child. This 36-minute film tells the story effectively and honestly.

The film can be rented from the Bureau of Visual Instruction, University of Wisconsin, 1323 West Johnson Street, Madison, Wisconsin, for a nominal fee. It is available for purchase through the Photographic Laboratory, 1204 West Johnson Street, University of Wisconsin Extension Division, Madison, Wisconsin.

# Society Proceedings

## Ashland–Bayfield–Iron

Fifteen members of the Ashland–Bayfield–Iron County Medical Society heard an address by *Dr. S. B. Crepea* of the University of Wisconsin Medical School, Madison, at their meeting on November 10 at the Menard Hotel, Ashland. Doctor Crepea spoke on "Diagnosis and Treatment of Severe Asthma."

Officers elected by the county society for the new year are:

President—*Dr. J. E. Kreher*, Ashland
Vice-President—*Dr. L. W. Moody*, Bayfield
Secretary–Treasurer—*Dr. J. M. Jauquet*, Ashland

## Brown–Kewaunee–Door

Members of the Brown–Kewaunee–Door County Medical Society advanced their regular meeting date by one day in November so as to combine their monthly meeting with the Postgraduate Teaching Program of the State Medical Society. The meeting was held at the Elks Club, Green Bay, beginning at 1:30 p.m., and topics discussed were:

"Hernias, Hydroceles, and Undescended Testicles," by Dr. Tague C. Chisholm, Minneapolis, Minnesota.

"The Treatment of Cardiac Emergencies," by *Dr. Charles W. Crumpton*, associate professor of medicine, University of Wisconsin Medical School, Madison.

"Special Problems of Breast Tumors as Related to General Practice," by *Dr. A. R. Curreri*, professor of surgery, University of Wisconsin Medical School.

"Danger Signals in Obstetrics," by Dr. William C. Keettel, professor of obstetrics and gynecology, University Hospitals, Iowa City, Iowa.

A short business meeting followed the scientific program, and the session adjourned at 6:00 p.m.

## Dane

The Dane County Medical Society held its regular monthly meeting at the Veterans Hospital, Madison, November 9, in conjunction with Dearholt Day.

Dr. Donald S. King, professor of thoracic medicine at Dartmouth Medical School, Hanover, New Hampshire, spoke on "Rest Versus Drugs in the Treatment of Tuberculosis."

## Fond du Lac

The October meeting of the Fond du Lac County Medical Society was held on October 28 at the Elks Club, Fond du Lac. Dinner was served at 7:00 p.m.

On November 18 the society met at Cap's Steak House in Peebles for dinner at 7:00 p.m. *Dr. William V. Luetke* of Madison spoke on "The 1953 Maternal Mortality Survey."

## Green

Twenty-seven members of the Green County Medical Society were present at the dinner meeting of the society at the Monroe Country Club on October 27.

*Dr. F. E. Mohs*, professor of chemosurgery at the University of Wisconsin Medical School, Madison, spoke on "The Excision of Cancer under Microscopic Control by the Chemosurgical Method."

*Dr. W. D. Stovall, Jr.*, Brodhead, delegate, reported on actions taken by the House of Delegates of the State Medical Society at its October meeting.

The county society members voted to support National Diabetes Detection Week.

## Green Lake–Waushara

On October 26 at the Hotel Whiting, Berlin, nine members of the Green Lake–Waushara County Medical Society heard an address by *Dr. G. G. Shields* of Wisconsin Rapids on "Recent Trends in Public Health Service." A general question-and-answer period followed.

During the business meeting of the society, *Dr. A. T. Leininger* of Green Lake was appointed as the liaison agent between the county society and the office of the Green Lake County nurse. Classes in child care to be presented to new mothers by the county nurses were approved.

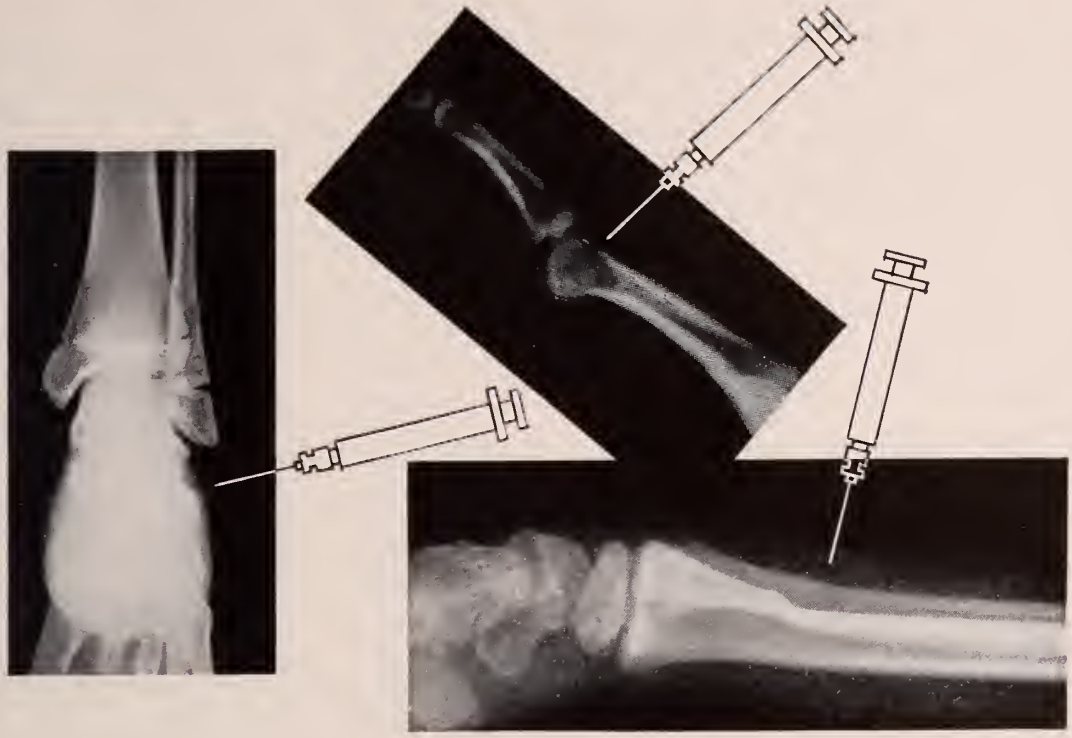
## Kenosha

*Dr. Edwin C. Albright*, associate professor of medicine at the University of Wisconsin Medical School, Madison, was the guest speaker at the Kenosha County Medical Society meeting on October 4 at the Elks Club, Kenosha. His talk was entitled "Thyroid Diseases with Special Reference to Radioactive Iodine."

Forty-two members of the society were present.

## Manitowoc

At the regular dinner meeting of the Manitowoc County Medical Society on November 18, Dr. Joseph Lalich, associate professor of pathology at the University of Wisconsin Medical School, Madison, spoke on 'Thrombosis." The meeting was held at the Hotel Manitowoc, Manitowoc.



# Use of Alidase® in Closed Wounds: Contusions, Sprains, Dislocations, Simple Fractures

*In traumatic surgery[1] where "definitive treatment . . . is often delayed while the surgeon waits for nature to dispose of hematoma and oedema" Alidase is an efficient means[1, 2] of accelerating dispersion of accumulated fluids.*

Swenson[2] has described his highly successful results with Alidase in various types of closed wounds. He summarized them as follows:

To remove local fluid accumulations in contusions or bruises. "The usual dose, 500 viscosity units Alidase® mixed in a small amount of normal saline, is injected into the localized fluid. Mixing the hyaluronidase in 1 per cent procaine solution will also produce local vasodilatation, relief of local pain and more rapid absorption of the fluid mass. This method can also be applied to traumatized bursae or synovial spaces which do not respond to repeated aspirations."

The point of maximal pain is infiltrated with 10 cc. of a 1 per cent procaine solution to which 500 viscosity units of Alidase have been added. With this simple technic, a high percentage of successful results has been obtained.

Alidase may be used to advantage to produce more rapidly a short-acting, complete block anesthesia and to facilitate reduction in subluxation or complete dislocations of the interphalangeal joints. When anesthesia is required for fracture reduction, local block anesthesia can be simplified by adding Alidase to the anesthetic solution. Alidase also tends to decrease local edema and hematoma formation.

Fluids administered with Alidase are rapidly absorbed from subcutaneous tissue. The simplicity of hypodermoclysis avoids the cumbersome arm board, permits convenient administration with little or no pain or swelling, is vein-sparing and saves nursing time in such conditions as burns, postoperative states, toxemias and parenteral alimentation.

Alidase (brand of hyaluronidase) is supplied in serum-type ampuls of 500 viscosity units. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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1. MacAusland, W. R., Jr.; Gartland, J. J., and Hallock, H.: The Use of Hyaluronidase in Orthopaedic Surgery, J. Bone & Joint Surg. *35-A*:604 (July) 1953.
2. Swenson, S. A., Jr.: Minor Surgical Aspects of Closed Wounds, Am. J. Surg. *87*:384 (March) 1954.

## Oconto

Officers for the new year were elected at the meeting of the Oconto County Medical Society on October 19 at the Alamo Club at Stiles. They include:

President-Elect—*Dr. A. F. Slaney*, Oconto
Secretary–Treasurer—*Dr. F. E. Zantow*, Oconto

*Dr. G. R. Sandgren*, Suring, who had served as president-elect during the last year, assumed the office of president at this meeting.

## Outagamie

At a meeting of the Outagamie County Medical Society at Riverview Sanatorium, Kaukauna, on October 21, the following officers were elected for the new year.

President—*Dr. F. J. Rankin*
Vice-President—*Dr. A. C. Taylor*
Secretary–Treasurer—*Dr. H. T. Gross*

All of the physicians are from Appleton.

Dr. D. L. Tabern, head of the department of Radioactive Pharmaceuticals, Abbott Laboratories, Chicago, spoke on "How Isotopes are Used in Medicine."

## Pierce–St. Croix

Twenty-one members of the Pierce–St. Croix County Medical Society met on October 19 at New Richmond to hear *Dr. J. P. Healy* of New Richmond speak on "Medical Economics." *Drs. A. R. Aanes* of Ellsworth and *G. J. Hopkins* of Hudson were discussants.

Members of the society appointed to the Diabetes Committee were *Drs. P. H. Gutzler*, River Falls; *P. W. Limberg*, Glenwood City; and *F. A. Springer*, Elmwood. *Drs. P. S. Haskins*, River Falls, and *G. J. Hopkins*, Hudson, were appointed to the Public Relations Committee.

The secretary, *Dr. P. H. Gutzler*, presented a report on the meeting of the State Medical Society held in Milwaukee in October. Doctor Healy reported on "Doctor Epley Day."

## Polk

The Polk County Medical Society met at Paradise Lodge, Balsam Lake, on October 21 as the dinner guests of *Dr. K. K. Ford* of Amery. Sixteen members were present.

Dr. Charles A. Neumeister of Minneapolis addressed the group on "Proctology of Importance in General Practice."

Officers elected by the society for the new year are:

President—*Dr. M. G. Marra*, Amery
Vice-President—*Dr. F. L. Whitlark*, Amery
Secretary–Treasurer—*Dr. L. J. Weller*, Osceola
Censor—*Dr. L. J. Weller*, Osceola
Delegate—*Dr. L. O. Simenstad*, Osceola
Alternate Delegate—*Dr. V. C. Kremser*, Amery

During the business session the county immunization program was discussed, and delegates reported on the October meeting of the State Medical Society. Members also discussed health insurance.

### Richland

*Dr.* and Mrs. *B. I. Pippin*, Richland Center, entertained the members of the Richland County Medical Society and their wives at dinner on October 28 at the Park Hotel.

The physicians held their regular meeting following dinner; and Dr. Ivan Baronfsky, associate professor of surgery at the University of Minnesota, Minneapolis, spoke on surgery of the heart.

### Rock

The Rock County Medical Society held its annual dinner and business meeting at the Monterey Hotel, Janesville, on October 26, at which time officers of the society were elected. They include the following:

President—*Dr. C. M. Carney*, Beloit
Vice-President—*Dr. F. M. Frechette*, Janesville
Secretary-Treasurer—*Dr. H. M. Snodgrass*, Janesville
Delegates—*Dr. Richard Thayer*, Beloit; *Dr. Milton Davis*, Milton
Alternate Delegates—*Dr. W. J. Mauermann*, Beloit; *Dr. E. R. Otterholt*, Janesville.

Doctors Thayer and Davis reported on the State Medical Society's Annual Meeting in October.

### Sauk

On November 9 a dinner meeting of the Sauk County Medical Society was held at 6:30 p.m. at the Warren Hotel, Baraboo.

"Progress of Rural Hospitals" was the topic discussed by Mr. Vincent Otis, director of the Division of Hospital and Related Services of the State Board of Health. Miss Elizabeth Terry, Sauk County Public Health Nurse, presented her program for the year. Twenty members of the society attended the meeting.

### Sheboygan

Forty members of the Sheboygan County Medical Society met on September 16 at the Riverdale Country Club, Sheboygan, to hear Attorney Herbert S. Humke of Sheboygan speak on "Cooperation Between the Medical and Legal Professions." A question-and-answer period followed.

The county immunization program was also discussed at the meeting.

### Winnebago

The November dinner meeting of the Winnebago County Medical Society was held November 4 at 6:30 p.m. at the Valley Inn Hotel, Neenah.


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*Dr. J. W. Harris*, chairman of the Department of Obstetrics and Gynecology at the University of Wisconsin Medical School, Madison, spoke on "Some Common Gynecological Mistakes."

## Wisconsin Academy of General Practice Waukesha–Jefferson County Chapter

*Dr. J. R. Howlett*, Hartland; *Dr. F. A. Gruesen*, Fort Atkinson; and *Dr. T. H. Nammacher*, Oconomowoc, were elected president, vice-president, and secretary–treasurer of the Waukesha–Jefferson County Chapter of the Wisconsin Academy of General Practice, organized on October 27. Twenty general practitioners of the area organized the chapter, which will meet quarterly.

Named as delegates to the Wisconsin Academy were *Drs. Harvey Mallow* of Fort Atkinson; *L. C. J. Olsen*, Delafield; and *Erwin Van Valin*, Sussex. *Drs. M. G. Peterson*, Lake Mills; *J. C. Frick*, Waukesha; and *T. H. Nammacher*, Oconomowoc, were elected alternate delegates.

## Milwaukee Neuro-Psychiatric Society

Members of the Milwaukee Neuro-Psychiatric Society were invited to attend a scientific program commemorating the seventieth anniversary of the Milwaukee Sanitarium on November 17.

Speakers included Dr. Frederic A. Gibbs, chief of the Division of Electroencephalography of the University of Illinois College of Medicine, who spoke on "Electroencephalographic Correlates of Behavior Disturbances and Psychiatric Disorders," and Dr. Howard P. Rome, professor of psychiatry at the Graduate School of Medicine, University of Minnesota and head of the Section on Psychiatry at the Mayo Clinic, who spoke on "Hormones and Behavior."

A business meeting of the society was also held.

## Milwaukee Oto-Ophthalmic Society

The following physicians have been reported as officers for the year 1954–5 in the Milwaukee Oto-Ophthalmic Society:

President—*Dr. Erwin E. Grossmann*
Vice-President—*Dr. Donald T. Hughson*
Secretary-Treasurer—*Dr. Howard V. Morter.*

The society holds monthly meetings from October through May on the fourth Tuesday, at the Milwaukee University Club at 6:00 p.m.

## Wisconsin Trudeau Society

When the Wisconsin Trudeau Society, the medical section of the Wisconsin Anti-Tuberculosis Association, met at the Veterans Hospital, Madison, on November 5, the following speakers appeared on the program:

*Dr. Palmer Kundert*, Madison — "Diagnostic Management of Urogenital Tuberculosis."
*Dr. Edwin Albright*, Madison—"Management of Diabetes Mellitus in the Tuberculous."

Panelists included *Drs. J. G. Russo*, Kaukauna; *John Mendenhall*, Madison; *Joseph Gale*, Madison; and *Richard Jahn*, Milwaukee.

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J. Frampton Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Earl H. Ninow, M. D.
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### Wisconsin Chapter, American College of Chest Physicians

The ninth annual meeting of the Wisconsin Chapter of the American College of Chest Physicians was held at the Schroeder Hotel, Milwaukee, October 3. About 200 state physicians attended.

Speakers discussed aspects of diseases of the chest, and eight exhibits on chest diseases were presented.

*Dr. E. L. Belknap*, Milwaukee, professor and director of the Department of Occupational Environmental Medicine at the Marquette University School of Medicine, was elected president of the group.

*Dr. Karl E. Kassowitz*, Milwaukee, associate professor of pediatrics at Marquette, was elected vice-president; and *Dr. L. H. Hirsh*, Milwaukee, associate in medicine at Marquette, was re-elected secretary-treasurer.

# News Items and Personals

### Doctor Arvold Returns to Shawano

After two years' service with the Air Force, *Dr. D. S. Arvold* returned to his practice at the Cantwell–Peterson Clinic at Shawano on October 4. He had been stationed in Milwaukee at the Air Force Training Center.

### Dr. V. C. Epley Enters Service

*Dr. V. C. Epley* of Prairie du Chien left his practice on October 18 to report for indoctrination in the Army. He reported at Fort Sam Houston, Texas.

### Doctors Springer at Minnesota Meeting

*Drs. Frank and Joseph Springer* of Elmwood attended postgraduate medical meetings held the first week of November. The meetings were in Minneapolis.

### New Physician Joins Marsh Clinic

*Dr. William J. Von Ruden* has become an associate in the practice of medicine and surgery at the Marsh Clinic, Shawano. A graduate of the University of Illinois College of Medicine, he recently completed a two-year rotating internship at Cook County Hospital, Chicago.

### Dr. R. A. Starr Resumes Viroqua Practice

Following two years' service in the Navy, *Dr. Robert A. Starr* has resumed his medical practice in Viroqua. He is in association with *Dr. R. S. Hirsch* and *Dr. H. E. Oppert.*

### Clintonville Physician Called to Active Duty

*Dr. R. E. Bolinske*, Clintonville physician for the past two years, left his practice on October 20 to enter active duty with the Air Force. He was stationed at Gunter Air Force Base at Montgomery, Alabama, for three weeks and then transferred to Tinker Air Field, Oklahoma City, for two years' service as a pediatrician.

### Staff Officers Re-elected at Fort Atkinson Hospital

Officers of the Fort Atkinson Memorial Hospital staff were re-elected at the hospital's annual meeting on November 9. They include the following Fort Atkinson physicians:

President—*L. H. Gueldner, M. D.*
Vice-President—*F. A. Gruesen, M. D.*
Recording Secretary—*J. C. H. Russell, M. D.*
Corresponding Secretary—Estelle Chase, M. D.
Chief of Surgery—*H. G. E. Mallow, M. D.*
Chief of Medicine—*J. J. Harris, M. D.*
Chief of Obstetrics—*O. H. Hanson, M. D.*

### Dr. C. A. Cooper, Colfax, Honored

The residents of the community of Colfax honored *Dr. C. A. Cooper* at a testimonial dinner given on November 7 at the Colfax High School Gymnasium. Doctor Cooper was born in Racine on October 5, 1876; was graduated from the University of Michigan Medical School in 1900; and began his practice at Lodi. In 1904 he moved to Montfort, where he practiced until 1912. He then moved to Norwalk and practiced there until 1918, when he entered military service. Following his discharge in 1919 he moved to Colfax, where he has practiced continuously.

The occasion of the testimonial dinner also marked the completion of 52 years' dental practice in the community by Dr. W. R. Brooks.

### Hudson Hospital Staff Officers Elected

At the November meeting of the staff of the Hudson Memorial Hospital, Hudson, *Dr. Paul S. Haskins* of River Falls was elected chief of the medical staff. Other officers elected were *Dr. J. E. Newton*, Hudson, vice-president, and *Dr. G. E. Bourget*, Hudson, secretary.

### Dr. N. J. Knauf Honored

Members of the Calumet County Medical Society and their wives gathered at the home of *Dr.* and Mrs. *A. C. Engel*, New Holstein, for a surprise celebration in honor of *Dr. N. J. Knauf* of Chilton

for his 50 years as a practicing physician and to observe his birthday anniversary, which occurred on October 18. The honored guest was presented with a gift of luggage from the group.

Doctor Knauf is a member of the Fifty Year Club of the State Medical Society.

## Sheboygan Doctors Attend Gastroenterological Meeting

*Drs. B. F. Eckardt* and *Joseph Kovacic* of Sheboygan attended the nineteenth annual convention of the National Gastroenterological Association the last week of October. The meeting was held in Washington, D. C.

## Doctor Miller at Dermatological Meeting

On October 29 and 30, *Dr. W. C. Miller*, Wausau, attended the meeting of the Minnesota Dermatological Society. Ancker Hospital, St. Paul, was the place of the meeting.

## Dr. F. B. Sazama at Postgraduate Assembly

*Dr. F. B. Sazama*, Chippewa Falls, attended the Interstate Postgraduate Medical Assembly during the first week of November. The meeting took place in Minneapolis.

## Doctors on Hospital Committee in Calumet County

Four Calumet County physicians have been selected to work as an advisory council with the Calumet Memorial Hospital Association's Board of Directors. They are *Drs. W. A. Langmack*, Brillion; *Francis Larme*, New Holstein; *Kenneth R. Humke*, Chilton; and *John Knauf*, Stockbridge. Plans are now under way to construct a new hospital in the county, and a site is expected to be selected in the near future.

## Doctors Receive ICS Degrees

Among those who recently received degrees in the International College of Surgeons are *Drs. Herbert W. Granzeau*, Burlington, associate, and *Nathaniel G. Rasmussen*, Montfort, junior membership. The degrees were awarded on September 10 in Chicago.

## Sheboygan—Fond du Lac MD's Visit Parke, Davis

Over 50 physicians from the Sheboygan and Fond du Lac area visited Parke, Davis & Company, Detroit, Michigan, on October 1. They visited the firm's research building and were given information about the company's pharmaceutical products and discoveries.


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## THIRD AND TWELFTH DISTRICTS NEWS

### Doctor Suckle Attends Meet

*Dr. Henry M. Suckle,* Madison neurosurgeon, attended the meeting of the Congress of Neurological Surgeons at the Waldorf Astoria Hotel in New York City, November 4 to 6. He is a member of the executive committee of the Congress.

### Dr. C. G. Reznichek Is Guest Speaker

*Dr. C. G. Reznichek,* Madison, was the guest speaker at the twenty-ninth annual meeting of the Wisconsin Association for the Disabled held at the Plankinton House, Milwaukee, on October 21. Doctor Reznichek is president of the Wisconsin Academy of General Practice.

### University of Wisconsin Medical School

At a special medical meeting at the University of Wisconsin Medical School on October 19, Dr. George Burch of New Orleans and Dr. S. G. Blount, Jr., of Denver appeared as guest speakers, sponsored by the Wisconsin Heart Association. Doctor Burch is Henderson professor of medicine and chairman of the Department of Medicine, Tulane University School of Medicine; and Doctor Blount is associate professor and director of the cardiovascular laboratory at the University of Colorado School of Medicine.

A lecture entitled "The Clinical and Epidemiological Characteristics of Amyotrophic Lateral Sclerosis and Multiple Sclerosis" was presented by Dr. Leonard Kurland of the Mayo Clinic, Rochester, Minnesota, at the medical school on November 18 at 8:00 p.m.

On November 29 at 11:00 a.m., Sir Lionel Whitby, Regius professor of physics at Cambridge University, Cambridge, England, spoke at a medical school convocation. His subject was "Splenic Function and Dysfunction."

### Doctor Kemp Joins Madison Physicians

*Drs. G. A. Cooper* and *C. W. Stoops, Jr.,* have a new physician, *Dr. Thomas Kemp,* with them in their practice. Doctor Kemp is a graduate of the University of Minnesota Medical School, interned at St. Luke's Hospital at Duluth, and did postgraduate work in dermatology at the University of Pennsylvania and the Philadelphia Skin and Cancer Hospital. He is a Diplomate of the American Board of Dermatology.

### Dr. H. L. Burdick Enters Air Force

*Dr. H. L. Burdick* of Milton has been recalled to active duty with the Air Force. Having served almost 16 months during World War II, he was retired in 1946. He will now complete 15 months' active duty and is presently stationed at Randolph Air Force Base in Texas.

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## Monroe Physician Certified by American Board

*Dr. Eugene E. Eckstam*, Monroe surgeon, recently became a Fellow in the International College of Surgeons and received certification as a specialist in surgery by the American Board of Surgery.

## Dr. Paul Snowden Attends Continuation Course

*Dr. Paul W. Snowden*, Monroe, attended a Continuation Center course at the University of Minnesota, Minneapolis, November 8 through 13.

## Dr. M. G. Peterman Lectures at Peoria

*Dr. M. G. Peterman*, Milwaukee, was the guest speaker at the Illinois Pediatric Society meeting on November 7. The meeting was held at Peoria, Illinois.

## Milwaukee Doctors at Gastroenterology Meet

*Dr. Michael W. Shutkin* and Dr. Donald Caine presented a paper at the national convention of the American College of Gastroenterology in Washington, D. C., on October 28. Their paper was entitled "The Clinical Value of Bilirubin Determinations in Routine Urine Analysis with an Improved Method."

*Dr. Joseph Shaiken*, Milwaukee, associate professor of medicine at Marquette University School of Medicine, was elected secretary of the American College of Gastroenterology at this meeting.

## SOCIETY RECORDS

### New Members

G. E. McGuire, 122 East Walnut Street, Green Bay.

R. G. Wochos, 130 East Walnut Street, Green Bay.

J. L. Teresi,* ** 201 Slagle Place, Fort Bragg, North Carolina.

J. K. Martins, Box 173, Eleva.

F. J. Erdlitz,** Dallas.

F. H. Goetsch, 640 Smith Street, Spooner.

W. J. VonRuden, 139 South Main Street, Shawano.

D. V. Clatanoff, 13 Sherman Terrace, Madison.

E. K. Ryder, Jr., 113 North Carroll Street, Madison.

James C. Pinney,** 1301 South Webster Avenue, Green Bay.

R. G. Bonfiglio, 130 West Wisconsin Avenue, Neenah.

G. O. Horn, 225 Bullard Court, Menasha.

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D. S. Arvold, Milwaukee, to Cantwell–Peterson Clinic, Shawano.

N. J. Kozokoff, Youngstown, Ohio, to 3348 Colwyn Road, Shaker Heights, Ohio.

J. G. Taylor, Milwaukee, to 4379 Ingraham Highway, Miami 33, Florida.

D. F. Hammond, Chetek, to Stromsburg, Nebraska.

R. L. Hartzell, Boise, Idaho, to Grantsburg.

E. E. Skroch,* Madison, to U. S. Naval Hospital, Great Lakes, Illinois.

Stephen Cahana, Milwaukee, to 1201 Westwood Boulevard, Los Angeles, California.

R. B. Foe, Omaha, Nebraska, to 2426 13th Avenue Court, Greeley, Colorado.

J. H. Mehnert,* Madison, to U.S.S. Princeton, % FPO, San Francisco, California.

J. C. Fox, La Crosse, to 42 Lincoln Street, Hingham, Massachusetts.

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E. F. McNichols, Amonate, Virginia, to 1457 Cherry Lane, Memphis, Tennessee.

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L. W. Keller, Reedsburg, to Webster, South Dakota.

J. W. Frye, Merrill, to Surgical Service, VA Hospital, 2615 Clinton Avenue, Fresno, California.

Alexander Schlapik, Kenosha, to Albert Pick Hotel, Bay Harbor Islands, Miami Beach 41, Florida.

G. E. Bryant, Cleveland, Ohio, to 3526 Brayton Avenue, Long Beach, California.

J. M. Sinnett, % FPO, New York, to 5757 Cedar Park Lane, Jacksonville, Florida.

Richard C. Brown,* Eau Claire, to 2622 North Von Dorn Street, Alexandria, Virginia.

*Correction:* D. M. Gallaher, Jr., 103 West College Avenue, Appleton.

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## DEATHS

**Dr. Willard Eugene Archer,** former Appleton physician, died on October 13 at Fall Creek, where he had been visiting a sister-in-law. He was 54 years of age.

Doctor Archer was born November 3, 1899, at West Union, Iowa, and was graduated from Marquette University School of Medicine in 1926. He practiced at Dale before moving to Appleton in 1939. In 1951 he accepted a staff position with the Veterans Administration Hospital at Tomah, and in 1952 he moved to the Anoka State Hospital at Anoka, Minnesota.

Doctor Archer was a former member of the Outagamie County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow; two daughters, Miss Patricia, Madison, and Mrs. Matthew Davis, Bremerton, Washington; one son, Thomas; and one grandchild.

**Dr. Frank P. Foley,** Dorchester physician for 42 years, died at his home on October 25. He had been in poor health for the past several years.

Doctor Foley, who was 82 years of age, was born at Montello in 1872. He was graduated from Rush Medical College, Chicago, in 1900 and following an internship, practiced at Neshkoro until 1909, when he moved to Dorchester. He discontinued full-time active practice several years ago but was active on a limited scale until the past year.

On May 27, 1950, a "Doctor Foley Day" celebration was held in his honor by more than 1,500 of his "babies," medical school classmates, neighbors, and friends. He was presented with a purse containing $1,100 on that occasion.

Doctor Foley was a member of the Clark County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, Katherine; four sons, Dr. C. J. Foley of Wautoma, Keith of Chicago, Kenneth of Casper, Wyoming, and Terrance of East St. Louis, Illinois; and four daughters, Miss Constance, Manitowoc, Mrs. Frances Cramsie, Tokyo, Japan, Mrs. Herman Nebel, East St. Louis, Illinois, and Miss Claire, New Orleans, Louisiana. A daughter, Katherine, preceded him in death.

**Dr. Fred E. Kosanke,** 72 years of age, died at his home in Watertown on November 9, following a short illness.

Doctor Kosanke, who was born on July 2, 1882, in Weyauwega, had retired from the active practice of medicine. He was graduated from the Hahnemann Medical College and Hospital in Chicago in 1917 and interned at Lakeview Hospital, Chicago. He practiced in Watertown from 1918 to 1927 and in Fond du Lac from 1927 to 1935; in 1935 he returned to Watertown, where he continued his practice until his retirement in 1952.


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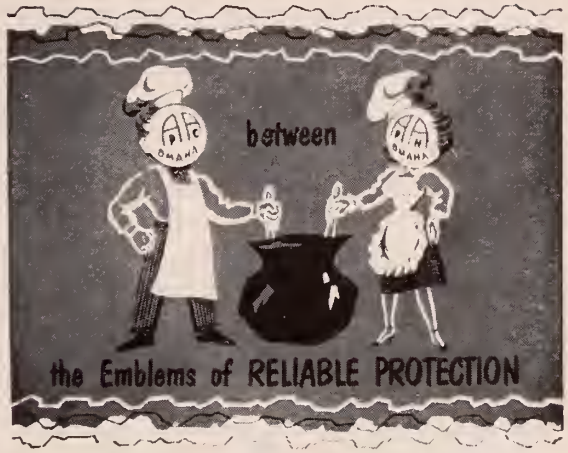


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He had served as secretary of the Jefferson County Medical Society in the past and had been secretary–treasurer of the Wisconsin State Homeopathic Society, recently being honored by that group for 25 years of faithful service.

He was a member of the Jefferson County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Doctor Kosanke is survived by his widow; his aged mother; a daughter, Mrs. Ralph Huston of Des Moines, Iowa; a son, the Reverend Frederic G. Kosanke of Altura, Minnesota; a brother, A. L. Kosanke of Weyauwega; and two grandchildren, Michael and David Huston.

**Dr. Archie A. Skemp,** 60 years of age, died on November 13 at a La Crosse hospital. He had practiced at La Crosse since 1918.

Born on August 13, 1894, in La Crosse, he received his medical degree from Washington University School of Medicine, St. Louis, in 1917. In 1918 he completed his internship at St. Francis Hospital, La Crosse.

He was a member of the La Crosse County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. He was a past president of the La Crosse County Medical Society.

His widow and seven children survive.

**Dr. Leland Trump,** Milwaukee, died at a Milwaukee hospital on November 14.

Born on February 15, 1885, Doctor Trump was 69 years of age. He was graduated from Marquette University School of Medicine in 1916.

Surviving are his widow, Anita; a foster daughter, Miss Dorothy Pratt, Milwaukee; a brother, J. D. Trump, Oak Park, Illinois; and two sisters, Miss Margaret, San Francisco, California, and Mrs. Jennie Jones, St. Petersburg, Florida.

**Dr. James Wallace Tanner** died on November 17 at his home in Eau Claire following the accidental discharge of his shotgun as he was preparing to leave on a hunting trip. He was 61 years of age.

Born January 27, 1893, in Franklin, Tennessee, Doctor Tanner was graduated from Rush Medical College in 1928. He completed an internship at Cook County Hospital, Chicago, in 1929 and a residency in eye, ear, nose, and throat at Cook County Hospital in 1931.

In World War I he served with the Naval Air Corps from 1917 to 1919.

Doctor Tanner was a Diplomate of the American Board of Ophthalmology and of the American Board of Otolaryngology. He was a member of the American Academy of Ophthalmology and Otolaryngology and the Central Wisconsin Society of Ophthalmology and Otolaryngology.

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His practice in Eau Claire was limited to the field of eye, ear, nose, and throat. He was a member of the staffs of Luther Hospital and Sacred Heart Hospital.

He was a member of the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association and had served as a member of the Committee on Hearing Defects of the State Society.

He is survived by his widow and two children. His son, James W., Jr., is a medical student at the University of Wisconsin Medical School.

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## Tribute to Dr. H. H. Christofferson by State Board of Medical Examiners

The following resolution of sympathy for the passing of Dr. H. H. Christofferson was adopted by the State Board of Medical Examiners at its October 15 meeting:

WHEREAS, the Supreme Ruler has called our former esteemed colleague, H. H. Christofferson, M.D., from this life; and

WHEREAS, Doctor Christofferson served as a member of this Board from 1937 to 1953, during which time he also wisely and faithfully acted for many years as President of the Board; and

WHEREAS, his integrity, diplomacy, fairness and untiring efforts to improve our board administration and the entire medical profession and to resolve medical problems with benefit to the people of Wisconsin and the nation, have provided an inspiration not only to the members of this Board, but likewise to those applicants who appeared before us seeking licensure in the State of Wisconsin; and

WHEREAS, the removal of such a doctor from our profession has left a vacancy which is difficult to fill,

*Now, therefore, be it resolved,* that this Board cause a copy of this expression of sympathy to be spread in its official records of this meeting, and that copies be sent to his survivor, his brother, A. M. Christofferson, M.D., Waupaca, Wisconsin, and to the following organizations with which he has been associated:

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American Medical Association
Federation of Medical Boards

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Address as follows: Medical Library Service. Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

**The Treatment of the Alcoholic.** By Fritz Kant, M. D., psychiatrist and neurologist, Madison, Wisconsin; Professor of Neuropsychiatry, University of Wisconsin Medical School. Springfield, Illinois, Charles C Thomas, 1954. Price $3.50.

This little volume, written by one who has had many years of practical experience in the treatment of alcoholics, is so written that it would be very understandable to any intelligent lay person; but the physician will profit much from perusing its content. It is of particular interest to attorneys, judges, clergymen, social workers, and the like.

The book is composed of about 25 very brief two- to seven-page chapters, commencing with "Why Do People Drink?" with the discussion of proper therapy, the matter of prevention, and the outlook for the future. Each chapter is very well written in an interesting manner, and the reviewer can assure any reader, regardless of his medical specialty, that much material of interest will be found in the book. The material as presented is logical, sound, and enlightening for those not working specifically in the field of treatment of the alcoholic. It is a fine book. —O. O. M.

**Peripheral Circulation in Man.** By G. E. W. Wolstenholme, O. B. E., M. A., M. B., B. Ch.; and Jessie S. Freeman, M. B., B. S., D. P. H., Editors for the Ciba Foundation; Assisted by Joan Etherington. Boston, Little, Brown and Company, 1954. Price $6.00.

This book is a highly specialized volume concerned with recent experimental work and methods in measuring peripheral blood flow. It will be of interest to those in the clinical field of peripheral vascular disease and very valuable to investigators currently working on peripheral vascular research problems. The beginner in research in any field will profit from the lively interchange of great research men discussing their mutual problems and bringing into critical focus their wide knowledge of the field under discussion and related biological and physical fields. The book has been edited so frankly that it gives one the feeling of being present at the discussion.

Although the material presented is so controversial that a novice is left quite confused, the alleged purpose of the book, that of bringing new published and unpublished work together in one place, has been accomplished very well.—G. G. R.

**Manual of Clinical Mycology.** By Norman F. Conant, Ph. D., Professor of Mycology and Associate Professor of Bacteriology, Duke University School of Medicine; David Tillerson Smith, M. D., Professor of Bacteriology and Associate Professor of Medicine, Duke University School of Medicine; Roger Denio Baker, M. D., Chief, Laboratory Service, Veterans Administration Hospital, Dunham, N. C., and Professor of Pathology, Duke University School of Medicine; Jasper Lamar Callaway, M. D., Professor of Dermatology and Syphilology, Duke University School of Medicine; and Donald Stover Martin, M. D., Chief, Bacteriology Section, Communicable Disease Center, Chamblee, Georgia. Second Edition. Philadelphia and London, W. B. Saunders Company, 1954.

A little more than 100 pages have been added to the new *Manual of Clinical Mycology.* Essentially, it is a revision of an excellent manual published in 1944 under the auspices of the Division of Medical Sciences of the National Research Council. The new chapters are three in number and are concerned with nocardiosis, tinea nigra palmaris, and coniosporiosus. In addition, the chapter revisions bring the manual up to date with regard to recent advances in chemotherapy of fungus infections and also present an excellent bibliography of the recent literature.

It is the opinion of the reviewer that this revised manual is, for the clinician, the most valuable presentation of the pertinent facts about fungus infections, their diagnosis and treatment.—D. S.

**Physical Therapy After Amputation. The Treatment of the Unilateral Lower Extremity Amputee.** By Margaret Bryce. Madison, The University of Wisconsin Press, 1954. Price $1.50.

The time when amputees were simply given a prosthesis and left to fence for themselves is fortunately long past. It has been realized that the training of the individual patient in the use of the prosthesis is as important as the correct fit of the

limb. Physical therapists are now trained to undertake this exercise program, and it is now generally taught in the physical therapy schools. So far, we have been handicapped by the lack of an adequate textbook. Professor Bryce's little book fills this gap most adequately. While the book is written primarily for physical therapy schools, it should prove valuable to the physician who has to advise the amputee with inadequate gait. Particularly valuable in this respect is the chapter on limps, in which causes and remedies are discussed.

In summary, this is a very valuable and intensely practical little book for those who have to deal with lower extremity amputees.—H. D. B.

**The Physician and His Practice.** Edited by Joseph Garland, M. D., Editor, *The New England Journal of Medicine.* Boston and Toronto, Little, Brown and Company, 1954. Price $5.00.

This book has been written as a source of information for the young doctor about to start his hospital training or to enter into the practice of medicine. The physician of long standing will also find it valuable in reassessing certain aspects of his practice and their relation to the community.

Dr. Joseph Garland, editor of the book as well as of *The New England Journal of Medicine,* has assembled 18 essayists of notable prominence in their respective fields to write on different features of medical practice. These topics deal, first, with the evolution of a physician, with his family and community relationships, the responsibilities of a doctor's wife, and the choice of opportunities for practice. Next, general medicine, specialty medicine, and group practice are characterized and the physician's relation to the hospital, medical organization, and his community discussed. Finally, detailed suggestions for the operation of a medical practice are given: suggestions regarding office equipment, the doctor's bag, laboratory supplies, records, economics, and legal aspects of medical practice.

The book is clearly written in an easy, informal manner with great frankness and earnestness. There is a very real feeling of each essayist's desire to give an informative, unprejudiced opinion. This reviewer believes that the book should be almost indispensable in guiding a young physician and that it might well be made required reading for the intern or resident about to start a career.—A. S. E.

**Respiratory Diseases and Allergy.** By Josef S. Smul, M. D., Fellow, National Gastroenterologic Association; Member, N. Y. Academy of Sciences; former Vice-President, Manhattan Roentgen Ray Society; Associate, Gastroenterology, Beth David Hospital; Clinical Assistant Phys., Beth Israel Hospital. New York, Medical Library Company, 1953. Price $2.75.

The author discusses diseases of the respiratory tract in 72 pages and, at best, therefore, gives merely a mention to the various diseases. Neoplastic diseases—definition, etiology, pathology, symptoms,


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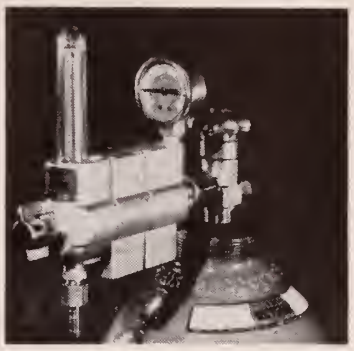

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diagnosis, and treatment are covered on one page, both sides. Other diseases of the nose, throat, and sinuses, as well as of the lungs, are similarly covered. Thirty-eight pages are devoted to allergy. The author here gives many novel ideas as far as etiology and treatment are concerned. Certainly many are not acceptable in the light of modern ideas. The use of dust, ragweed, and bacterial vaccines as "universal respiratory desensitizers" is hardly an acceptable procedure.

The book is not recommended.—S. B. C.

**Coronary Heart Disease in Young Adults.** By Menard M. Gertler, M. D., and Paul D. White, M. D., with the aid, advice, and editorial assistance of E. F. Bland, M. D., J. Fertig, Ph.D., S. M. Garn, Ph.D., J. Lerman, M. D., S. A. Levine, M. D., H. B. Sprague, M. D., N. C. Turner, M. Sc., Cambridge, Mass., for The Commonwealth Fund by Harvard University Press, 1954. Price $5.00.

This book is the summary of three years' work by a team of investigators who studied 100 subjects under 40 years of age who had had a proved coronary occlusion. The study covered anthropologic, biochemical, neuropsychiatric, and medical aspects of these patients.

The observations recorded are chiefly descriptive in an attempt to determine what factors separate the coronary sclerotic subject from the rest of the population. This is most difficult since a suitable group of controls has to be selected from the population at large and any method of selecting controls is open to criticism. The authors chose as "matched controls" those whose age, height, weight, occupation, and ethnic origin were similar to the coronary sclerotic subjects and then determined differences between the two groups. That significant differences were found shows that such a method of selection will not separate those who are coronary sclerotic subjects from those who are not.

Findings correlated significantly with coronary sclerosis were male sex, endormorphic mesomorph physique, slight cholesterol and uric acid metabolic abnormalities, and changes in saliva potential. None of these tests clearly separated the individuals of the two groups, although the averages of the groups were different.

The material is covered in a lucid manner, well illustrated by charts and graphs and carefully summarized at the end of each section and at the end of the book. Thus, the casual reader may quickly decide which sections he is further interested in and which present material new to him.—G.G.R.

**Textbook of Pediatrics.** Edited by Waldo E. Nelson, M. D., Professor of Pediatrics, Temple University School of Medicine, Medical Director of Saint Christopher's Hospital for Children, with the collaboration of seventy contributors. Sixth Edition. Philadelphia and London, W. B. Saunders Company, 1954.

The sixth edition of this excellent textbook has been completely revised in the construction of the

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table of contents and in format to make it a more useful and readable reference book. Many sections and chapters have been completely revised to bring them up to date. Some have been rewritten by new authors and co-authors to bring fresh opinions on important subjects to the reader.

Although the book is 100 pages shorter than the fifth edition, more space is devoted to important subjects such as the newborn and premature infant. A chapter on radiation injury and a very complete chapter on neoplasms and other tumors of infancy and childhood have been added. The illustrations, tables, and appendix are again of exceptional quality and usefulness.—K.B.M.

**Beyond the Germ Theory.** Iago Galdston, M. D., Editor. New York and Minneapolis, New York Academy of Medicine, Health Education Council, 1954. Price $4.00.

This book is concerned with the influence of various deprivations and stresses on the causation of disease. The book is divided into four parts. The first deals with the dynamics of deprivation and stress; and the various chapters point out many of the important relationships between noxious agents, and stresses of various kinds and how they may contribute or aggravate various diseases.

The second part relates to nutritional deprivation and stress and begins with the historical background of malnutrition in disease, followed by a discussion of deprivation of essential foodstuffs in pregnancy and childbearing. Consideration is given to the role of nutritional deprivation in old age and its role in geriatric disease.

Physicians in general are becoming increasingly aware of the role of psychological deprivation on the emotional growth and development of children. The third section of this book deals with experimental studies on the psychological effects of deprivation and also on the unhappy and fatal outcomes of emotional deprivation that may occur in infancy. The classical studies by Spitz with orphans and lost war children are summarized.

The fourth portion deals with the influence of social stresses and deprivation, the relationship of the social emotions, and the influence of the family on the community life, with the possibilities that these have on disease states.

The book is edited by Dr. Iago Galdston, who has welded together the various aspects of the subject in this book by pointing out that emotions of the individual are important to himself and to his family. The emotions of the family are related to the problems present in the community. The resultant disturbances that occur in society certainly reflect back on the members of the family and on their emotions. The recognition of the fact that disease can be caused by circumstances "beyond the germ theory" is receiving wide attention by physicians everywhere, and this volume published by the New York Academy of Medicine attests to its importance. —H.A.W.

**Current Therapy 1954.** Edited by Howard F. Conn, M. D. Philadelphia and London, W. B. Saunders Company, 1954.

As in past editions, this annual revision contains presently used, detailed methods of treatment for an amazingly complete list of diseases. The methods


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Basic Principles in General Surgery, Two Weeks, March 28
General Surgery, Two Weeks, December 6, 1954; One Week, February 14
Gallbladder Surgery, Ten Hours, April 11
Fractures & Traumatic Surgery, Two Weeks, March 14
GYNECOLOGY—Office & Operative Gynecology, Two Weeks, February 14
Vaginal Approach to Pelvic Surgery, One Week, February 7
OBSTETRICS—General & Surgical Obstetrics, Two Weeks, February 28
MEDICINE—Two-Week Course, May 2
Electrocardiography & Heart Disease, Two Weeks, March 14
Gastroenterology, Two Weeks, May 16
Gastroscopy, Two Weeks, March 21
RADIOLOGY—Diagnostic Course, Two Weeks, January 3
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of treatment given are those used personally by recognized authorities. For the most part, the methods are presented very specifically. Frequently, more than one method of treatment for a single disease or syndrome is presented by two or more authorities. The presentation is direct and without involved discussions, making the material available for quick answers and aiding the physician to plan suitable therapy for patients once diagnoses have been established.

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FOR SALE: One new Precision-Thelco electric incubator, inside dimension 13 x 14 x 15 inches. Never used. $80. Address replies to Box 560 in care of the Journal.

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WANTED: Psychiatrists or young doctors interested in psychiatry to work at Mendota State Hospital. Positions are permanent and under Civil Service, salary depends upon previous experience and training. Contact Dr. W. J. Urben, Superintendent, Mendota State Hospital, Madison 9, Wisconsin.

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WANTED: Assistant in EENT or physician capable of doing refraction. Address replies to Box 571 in care of the Journal.

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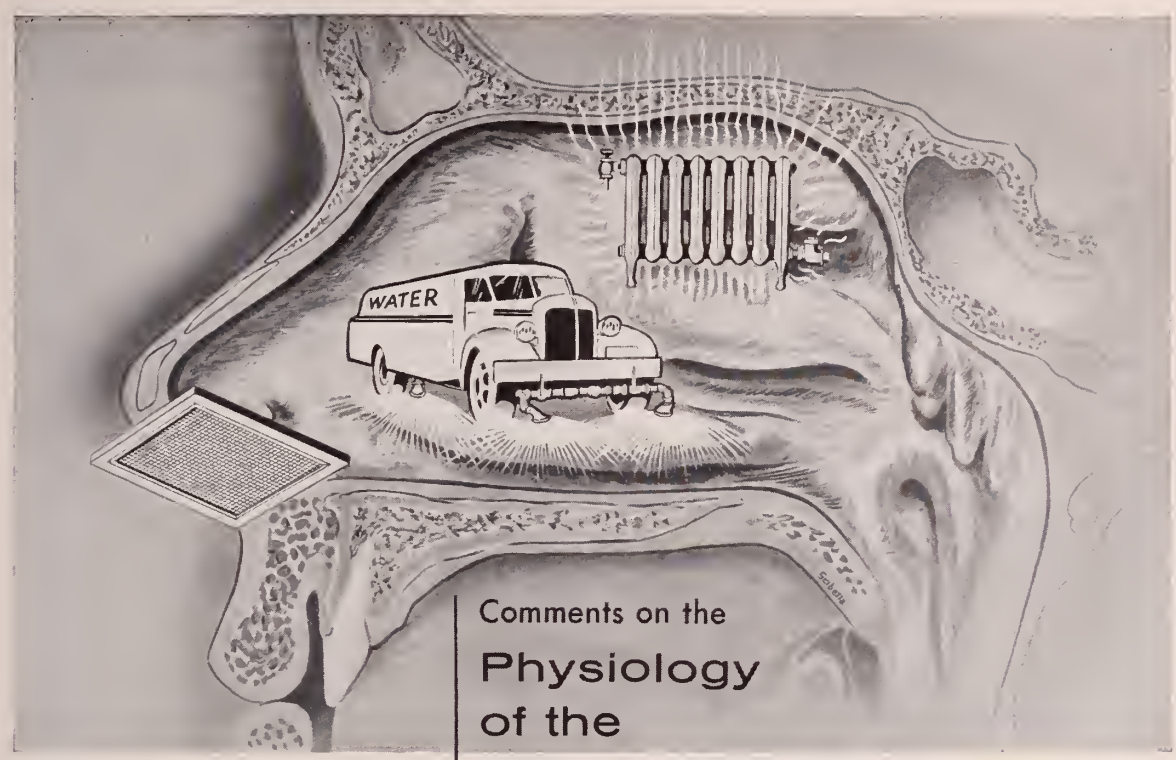


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## List of Officers and Scheduled Meetings of County Medical Societies

| COUNTY | PRESIDENT | SECRETARY | MEETING DATE |
|---|---|---|---|
| Ashland-Bayfield-Iron | J. E. Kreher<br>Ashland | J. M. Jauquet<br>901 9th Ave., W.<br>Ashland | |
| Barron-Washburn-Sawyer-Burnett | W. F. Vaudreuil<br>Rice Lake | D. F. Hammond<br>Chetek | Second Tuesday<br>7:30 p.m. |
| Brown-Kewaunee-Door | G. B. Merline<br>De Pere | G. M. Shinners<br>409 E. Walnut<br>Green Bay | Second Thursday* |
| Calumet | F. P. Larme<br>New Holstein | J. M. Guthrie<br>Brillion | |
| Chippewa | C. A. Kemper<br>119½ Bridge<br>Chippewa Falls | Paul Murphy<br>Bloomer | Second Tuesday |
| Clark | K. F. Manz<br>Neillsville | J. W. Koch<br>Colby | |
| Columbia-Marquette-Adams | J. P. Harkins<br>Portage | F. W. Gissal<br>132 Washington Ave.<br>Wisconsin Dells | Every Third Month<br>7:00 p.m. |
| Crawford | | H. L. Shapiro<br>Prairie du Chien | |
| Dane | G. C. Hank<br>110 E. Main<br>Madison | T. V. Geppert<br>113 N. Carroll<br>Madison | Second Tuesday |
| Dodge | T. C. Davis<br>109 Front<br>Beaver Dam | R. A. Knudson<br>Horicon | Last Thursday* |
| Douglas | C. J. Picard<br>2029 E. Fifth<br>Superior | R. P. Fruehauf<br>1514 Ogden<br>Superior | First Wednesday**<br>Badger Room of the<br>Hotel Superior |
| Eau Claire-Dunn-Pepin | K. L. German<br>219 S. Barstow<br>Eau Claire | G. E. Wahl<br>616 E. Grand<br>Eau Claire | Last Monday |
| Fond du Lac | N. O. Becker<br>104 S. Main<br>Fond du Lac | H. J. McLane<br>80 Sheboygan St.<br>Fond du Lac | Fourth Thursday* |
| Forest | O. S. Tenley<br>Wabeno | D. V. Moffet<br>Crandon | |
| Grant | J. J. David<br>Cassville | H. W. Carey<br>Lancaster | Last Thursday.<br>March, June,<br>Sept. and Nov. |
| Green | N. E. Bear<br>Monroe | D. E. Mings<br>Monroe Clinic<br>Monroe | |
| Green Lake-Waushara | Russell Pelton<br>Markesan | L. S. Shemanski<br>Wautoma | Last Thursday,<br>every other month<br>starting in Jan. |
| Iowa | C. L. White<br>Mineral Point | H. M. Walker<br>Dodgeville | First Thursday<br>following<br>first Monday |
| Jefferson | E. J. Netzow<br>Lake Mills | H. N. Hunsader<br>111 S. Main<br>Fort Atkinson | Third Thursday* |

* Except June, July, and August.
** Except July and August.

## List of Officers and Scheduled Meetings of County Medical Societies—Continued

| COUNTY | PRESIDENT | SECRETARY | MEETING DATE |
|---|---|---|---|
| Juneau | J. S. Hess<br>Mauston | John E. Thompson<br>Mauston | Second Tuesday<br>Hess Clinic in<br>Mauston |
| Kenosha | Richard M. Block<br>520 58th<br>Kenosha | Helen A. Binnie<br>7609 25th<br>Kenosha | First Thursday*<br>Elks Club<br>Kenosha |
| La Crosse | C. F. Midelfort<br>1836 South Ave.<br>La Crosse | Arnold A. Cook<br>1707 Main<br>La Crosse | Third Monday |
| Lafayette | N. A. McGreane<br>128 E. Ann St.<br>Darlington | R. E. Oertley<br>Darlington | Last Tuesday |
| Langlade | M. J. Donohue<br>Antigo | F. H. Garbisch<br>Antigo | Second Wednesday |
| Lincoln | Walter Lewinnek<br>700 E. Third<br>Merrill | J. D. Millenbah<br>Merrill | |
| Manitowoc | Nelson Bonner<br>709 Washington<br>Manitowoc | W. S. Marshall<br>1522 Washington<br>Two Rivers | Last Thursday |
| Marathon | H. W. Christensen<br>501½ Third<br>Wausau | A. W. Hoessel<br>115 McIndoe<br>Wausau | |
| Marinette-Florence | Kenneth Moss<br>1554 Main<br>Marinette | R. J. Rogers<br>Oconto | Third Wednesday<br>St. Joseph's Hospital |
| Milwaukee | J. G. Garland<br>324 E. Wisconsin<br>Milwaukee | Donald M. Willson<br>324 E. Wisconsin<br>Mr. J. O. Kelley, Ex. Sec.<br>208 E. Wisconsin | Second Thursday |
| Monroe | C. E. Kozarek<br>Tomah | J. S. Mubarak<br>Tomah | Third Monday |
| Oconto | G. R. Sandgren<br>Suring | F. E. Zantow<br>Oconto | |
| Oneida-Vilas | G. R. Thuerer<br>1020 Kabel<br>Rhinelander | Marvin Wright<br>1020 Kabel<br>Rhinelander | Monthly |
| Outagamie | F. J. Rankin<br>401 N. Oneida<br>Appleton | H. T. Gross<br>103 W. College<br>Appleton | Third Thursday*<br>Elks Club<br>6:30 p.m. |
| Pierce-St. Croix | F. B. Klaas<br>East Ellsworth | P. H. Gutzler<br>River Falls | Third Tuesday |
| Polk | M. G. Marra<br>Amery | L. J. Weller<br>Osceola | Third Thursday<br>7 p.m. |
| Portage | V. A. Benn<br>Rosholt | H. A. Anderson<br>Stevens Point | |
| Price-Taylor | E. B. Elvis<br>Medford | J. J. Leahy<br>Park Falls | Last Saturday,<br>Feb., May, Aug.,<br>and Nov. |
| Racine | S. J. Faber<br>610 Sixth<br>Racine | Eugene Pitts<br>420 Seventh<br>Racine | Third Thursday |
| Richland | R. E. Housner<br>Richland Center | L. M. Pippin<br>Richland Center | First Tuesday<br>Richland Hospital |
| Rock | C. M. Carney<br>403 E. Grand Ave.<br>Beloit | H. M. Snodgrass<br>508 W. Milwaukee<br>Janesville | Fourth Tuesday |
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| Sauk | O. V. Pawlisch<br>Reedsburg | J. J. Rouse<br>Reedsburg | Second Tuesday* |
| Shawano | R. C. Cantwell<br>Shawano | A. J. Sebesta<br>Shawano | Third Tuesday |
| Sheboygan | J. F. Kovacic<br>925A N. Eighth<br>Sheboygan | Keith M. Keane<br>1011 N. Eighth<br>Sheboygan | First Thursday |
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| Wood | H. G. Pomainville<br>Wisconsin Rapids | N. J. Helland<br>Marshfield | Four times a year |

* Except June, July, and August.

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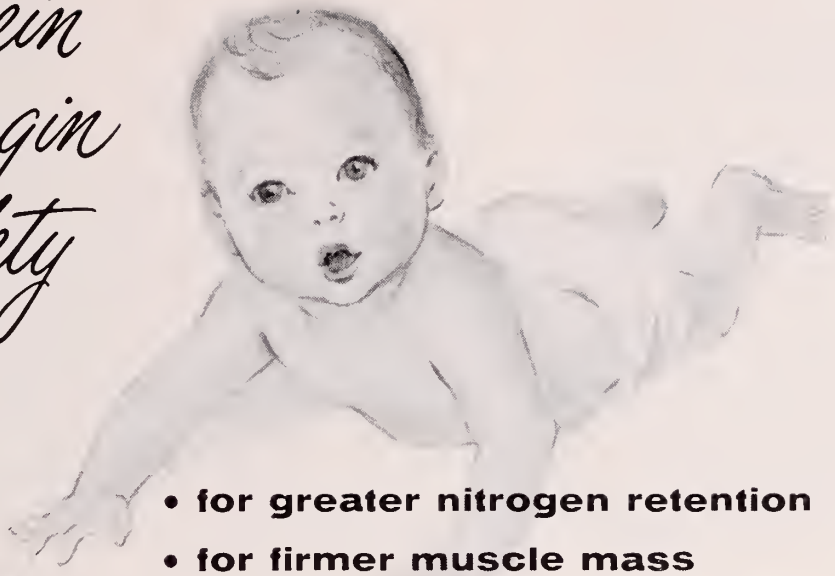

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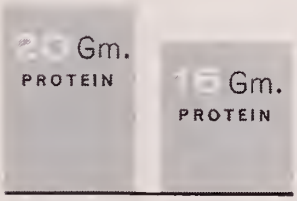


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